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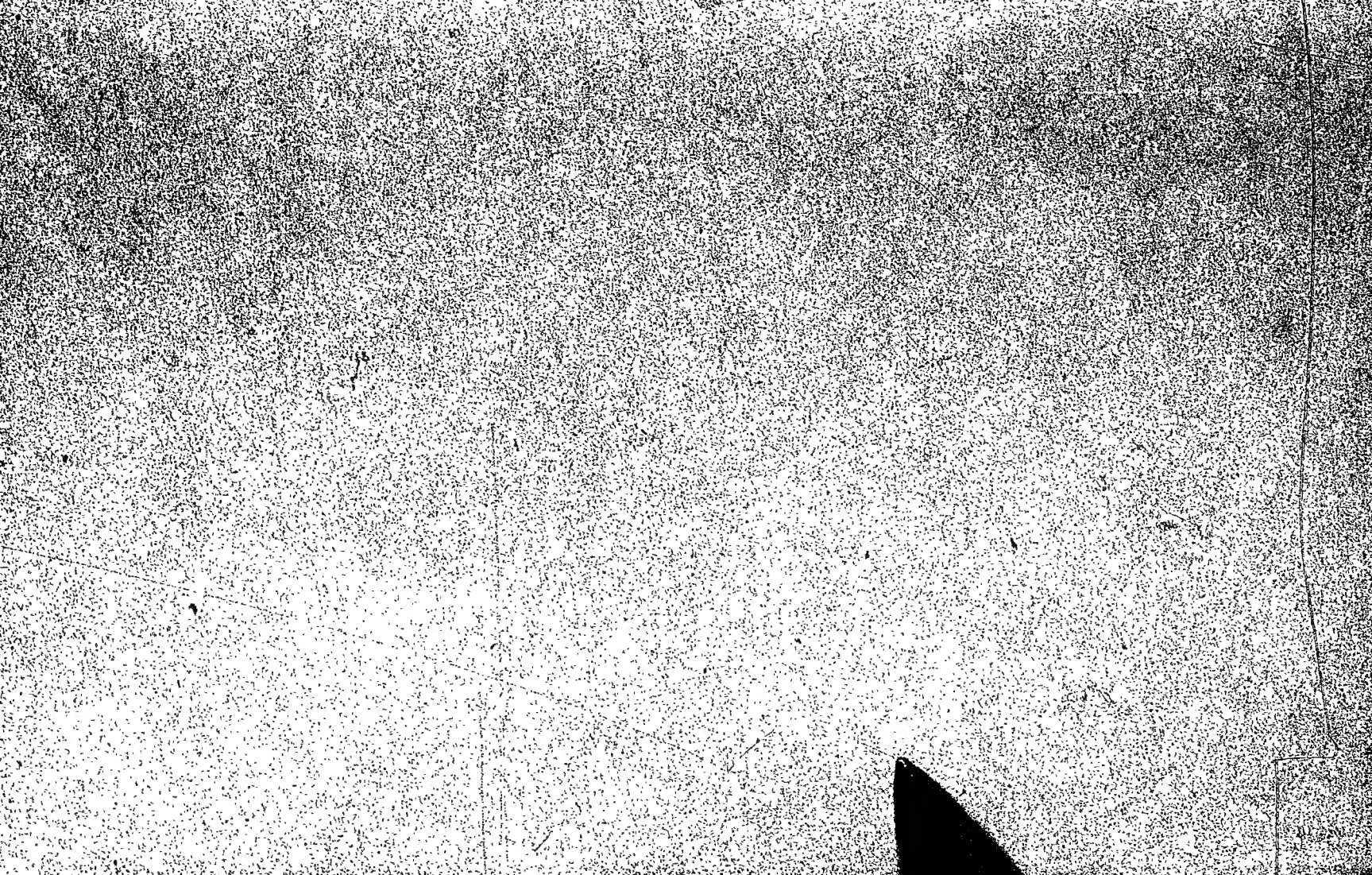
PUBLIC HEALTH IN MANITOBA

1941

REPORT OF A STUDY
made by the
AMERICAN PUBLIC HEALTH ASSOCIATION
1790 Broadway, New York, N. Y.



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FOREWORD

THE modern concept and progressive broadening of the public health program are placing new demands on official health agencies. Fundamental and radical changes in the health program must be accompanied by careful and intensive study of the facilities for health administration, federal, provincial and local.

Realizing this need, the American Public Health Association has made provision for comprehensive health studies in a few carefully selected states and provinces.[1] To determine states and provinces for study and to provide general supervision and guidance in the conduct of the studies, the Committee on Administrative Practice of the American Public Health Association appointed a subcommittee on State and Provincial Health Studies.[2] The selection of a province or state for study is determined, first, by the invitation and its sponsorship; second, by the need for a study, and third, by the possible utilization of the findings and recommendations of the study. Manitoba was granted a study because the subcommittee on State and Provincial Health Studies believed the province met these conditions and had sufficient leadership and general interest to apply the expression of the report to the lives of the people.

"Public Health in Manitoba" is a report of the study of Manitoba's health administration made at the request of the Provincial Minister and Deputy Minister of Health and Public Welfare.

The survey was made by the field staff of the American Public Health Association.[3] The staff gratefully acknowledges the enthusiastic interest and help of the Minister and Deputy Minister of Health and Public Welfare of Manitoba and of the personnel of that department. It also expresses its deep appreciation of the cordial interest and cooperation of Ministers and personnel of other provincial departments, of the Winnipeg City Health Officer and his staff, of the Manitoba Division of the Canadian Medical Associa-

tion, the Manitoba Dental Association, the Canadian Foundation for Preventive Dentistry, the Cancer Relief and Research Institute, the Health Officers of Brandon, St. Boniface, and St. James-St. Vital, the Manitoba Federation of Agriculture, the Union of Municipalities, the Manitoba Sanatorium Board, the Dominion-Provincial Youth Training Program, the Manitoba Association of Registered Nurses, and the superintendents of the institutions caring for mental disease and defectives, tuberculosis and the acute communicable diseases.

Although sponsored by the American Public Health Association and more specifically by its subcommittee on State and Provincial Health Studies, the statements in this report are those of the field staff and do not necessarily represent the opinion of the American Public Health Association or its subcommittee on State and Provincial Health Studies.

[1]The Manitoba and other state and provincial health studies have been made possible by a grant from The Commonwealth Fund to the American Public Health Association.

[2]The members of the subcommittee on State and Provincial Health Studies are:

Robert H. Riley, M.D., Director of the State Department of Health of Maryland (Chairman).

Eugene L. Bishop, M.D., Medical Director of the Tennessee Valley Authority, Chairman of the Committee on Administrative Practice of the American Public Health Association (EX officio).

J. N. Baker, M.D., State Health Officer of Alabama.*

Earle G. Brown, M.D., Health Commissioner of Nassau County, New York.

C. F. Dalton, M.D., Secretary of the State Board of Health of Vermont.

W. F. Draper, M.D., Assistant to the Surgeon General, U. S. Public Health Service, Washington, D.C.

Martha M. Eliot, M.D., Assistant Chief of the U. S. Children's Bureau.

Donald G. Evans, M.D., Director of the State Department of Health of Washington.

John A. Ferrell, M.D., Associate Director, International Health Division of the Rockefeller Foundation (Consultant).

Edward S. Godfrey, Jr., M.D., State Commissioner of Health of New York.

Frederick W. Jackson, M.D., Deputy Minister of Health and Public Welfare, Province of Manitoba, Canada.

Arthur T. McCormack, M.D., State Commissioner of Health of Kentucky.

I. C. Riggin, M.D., State Health Commissioner of Virginia.

W. Frank Walker, Dr. P. H., Director, Division of Health Studies of The Commonwealth Fund.**

W. C. Williams, M.D., State Commissioner of Public Health of Tennessee.

*Died November 9, 1941.

**Died September 27, 1941.

[3]Carl E. Buck, Dr. P. H., Field Director; Benjamin G. Horning, M.D., Associate Field Director; and Edith M. Boyd, Field Secretary, American Public Health Association.

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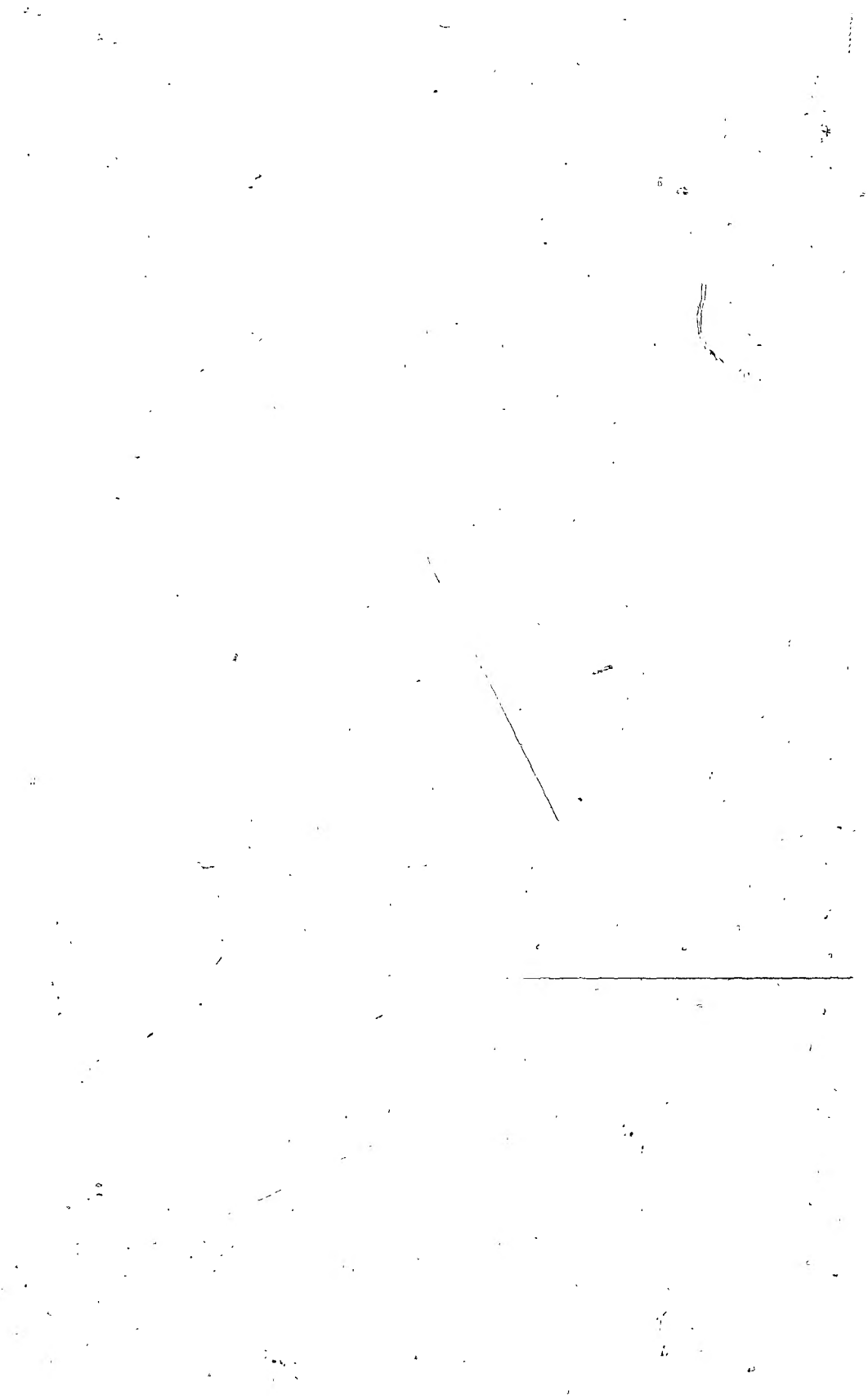

PUBLIC HEALTH IN MANITOBA

SCOPE OF STUDY

This study of public health administration in Manitoba attempts a reasonably comprehensive, but not detailed, scrutiny of present problems and of the facilities and activities to meet those problems, and suggests future plans for extending and improving health services in the Province. It does not pretend to evaluate the detailed techniques of the various services.

Suggestions and recommendations will be found throughout the report. Recommendations considered of particular significance have been assembled in a special section under the caption "Major Recommendations."

This study deals largely with activities commonly regarded as the minimal essentials in a modern public health program.* The report recognizes, however, that these constitute a limited definition of public health and that a true concept must include wider ramifications of medical and dental care, child welfare and other public welfare activities, general and special hospital facilities, the health aspects of the entire educational system, mental hygiene, the prevention of accidents, and the control or alleviation of such diseases as cancer, heart diseases, and diabetes. Pneumonia must also be considered as part of the communicable disease program. The broad administrative aspects of providing province-wide public health services on this basis to the people of Manitoba are discussed in these pages. A report has already been submitted dealing with public health administration in the City of Winnipeg.

*Vital Statistics and Records; Communicable Disease Control and Prevention, including Tuberculosis, and Syphilis and Gonorrhea; Public Health Laboratory Services; Maternal and Child Health, including Prenatal, Delivery, Postnatal, Infant, Preschool and School Health Services; Environmental Sanitation including water supplies, sewage disposal, the control of milk, meat and other foods and food products; Industrial Hygiene including public health aspects of plumbing and some attention to housing; general as well as specific Health Education or health information; Public Health Dentistry, Nutrition, Mental Hygiene and Public Health Nursing are assumed to be necessary integral parts of the program.

IMPORTANT FACTORS AFFECTING PUBLIC HEALTH ADMINISTRATION IN MANITOBA

The results of a plan depend upon many things, some influenced by governmental structure, and others subject to varying factors, such as climate, population, industry and per capita wealth. For optimum development and progress, there must be a just appraisal of these determinants and an appreciation of the effect of economic, physical, industrial, mental and racial environments.

In considering the public health services in Manitoba and the recommendations suggested for the future, several points should constantly be borne in mind:

1. That eventual worth of any provincial or state public health program will depend upon its success in establishing or having established adequate full-time local health service.
2. The essential functions of a provincial or state health department should be:
   (*a*) To stimulate an understanding of the value of and therefore a demand for adequate full-time local health service.
   (*b*) To provide supervisory, consultation-advisory field service to local health units as the most effective means of assisting such units to supply adequate health services geared to local needs rather than direct service to local communities from the Central Office.
   (*c*) As full-time local health units are developed, to provide for areas not having full-time health departments only emergency services and those highly technical or specialized services, the local procurement of which would be unfeasible or uneconomic even if the area had full-time local health service. In short, the fundamental aim of the provincial health program should be to guide and help local areas take care of themselves rather than to attempt doing the job for them.

It is fully appreciated, however, that the process of attaining these objectives must be evolutionary and not revolutionary in character.

Governmental structure and population distribution are particularly significant in a discussion of the special factors affecting public health administration in Manitoba. The entire situation as it affects public health and for that matter every other public activity is quite different in Canada from in the United States.

The Minister of Health and Public Welfare is appointed by the Lieutenant-Governor-in-Council, on the advice of the Premier, for a five-year term of office. He must be a member of Parliament. Under ordinary circumstances he would be a member of the same party as the Premier. However, at present there is a coalition government and it happens that the Minister of Health and Public Welfare belongs to the opposition. There are no professional quali-

fications for the Minister. He is the titular head of the Department, signs all orders and important papers and communications, and may, if he so desires, actually direct the Department. The present Minister of Health is a lawyer who is also the Attorney-General. The wise minister—and this is a wise minister—permits the deputy minister, who is and must be a professionally qualified person, to direct the Department. The Minister himself acts as liaison officer between the Department and the political group represented by Parliament and the Cabinet, which consists of the Premier and his twelve ministers. The Deputy Minister must, however, obtain the permission or written approval of the Minister for all important decisions or changes in policy.

The Deputy Minister, who must be a physician with a diploma in public health, is appointed by the Lieutenant-Governor-in-Council on the recommendation of the Minister, and must be approved by the Civil Service Commission. Once appointed and having met the qualifications of training and experience for the position, the Deputy Minister serves indefinitely and without fear of provincial political changes except of course as the attitude of his Minister may affect the functioning of his Department.

This system has two obvious advantages over the one commonly in practice in the United States:*

1. It insures continuity of professionally qualified leadership for the Department.
2. It leaves the executive head of the Department free to devote himself almost solely to professional duties.

However, like almost everything else in life, it is subject to the personal equation. If the Minister does not choose to abide by this division of authority and function, he does not have to do so. The prerequisites for effective administration under this system then are a strong and tactful deputy minister and a wise and tactful minister.

The task of supplying adequate local health service to the province is an exceptionally difficult one. At present there are four full-time health units serving 273,256 people, or 39.0 per cent of the total population. Three of these units are in Winnipeg and its suburbs. The fourth is in the next largest center, Brandon, a city of 16,461.

The Province of Manitoba covers an area of some 246,500 square miles and has approximately 700,000 population. There is no place in the United States quite like it. From the standpoint of type of people and occupation, Minnesota is probably the nearest

*There is one serious drawback to the plan as it operates in Manitoba which will be discussed later in this report.

parallel although of course there are not nearly so many Scandinavians in Manitoba. From the angle of supplying local health service, Manitoba might be compared with New Mexico or possibly Texas.

Railroad transportation radiates from Winnipeg like the spokes of a wheel, reaching nearly all the more densely settled areas in the Province. A community of five hundred or more is considered quite a center. Almost half of the entire population is to be found in Winnipeg and its suburbs. Of the remainder the major portion is to be found in a narrow belt running East and West (mostly West) from Winnipeg, East toward the Ontario border and West toward Saskatchewan. This population can be reached the year around by good all-weather roads. Much of the remainder of the Province can be reached by automobile in good weather only.

Although Winnipeg is the second largest fur center in the world and has a few manufacturing plants for war materials in or near the city, the Province is essentially agricultural in character. Wheat is the principal crop. With the exception of a small minority of progressives, the people are conservative in their thinking and actions.

There are two types of local government in Manitoba, city and municipal. In Canada any community of ten thousand or over is a city and is governed by a mayor and a city council. A municipality is composed of from three or four to as many as six or seven unincorporated villages and townships and is governed by a reeve and a municipal council. There are also "Unorganized" and "Disorganized" areas. Unorganized areas have no local government and are administered by the Provincial Government. Disorganized areas, of which there are four or five, are former municipalities which were unable to carry on successfully, and were therefore taken over by the Provincial Government.

It is reasonably simple to supply local health services to the populous sections along the belt East and West from Winnipeg. It is extremely difficult to furnish such services to the more sparsely settled areas. The most important reasons for this are the limited numbers and relative poverty of the people and the inadequate transportation facilities, particularly in winter and rainy weather. The type of local government adds still further to the difficulty.

PRESENT STATUS OF PUBLIC HEALTH

Public health work through official agencies in Manitoba is administered by the Provincial Department of Health and Public Welfare, the Dominion Government, the full-time health depart-

ments of Winnipeg, Brandon, St. Boniface, and St. James-St. Vital (comprising, as we have said, a population of 273,256 or 39.0 per cent of the total population), some 170 part-time health officers of whom sixteen are also municipal doctors, the Provincial Department of Education, the Manitoba Sanatorium Board, the Cancer Relief and Research Institute, and the Canadian Foundation for Preventive Dentistry. The last three may be considered as quasi-official, for, while organized as voluntary agencies, they do receive substantial amounts from tax funds. All of these are agencies which actually administer public health.

There are a great many other groups and agencies participating in and contributing to the advancement of public health. An incomplete list would include:

The Manitoba Division of the Canadian Medical Association.
The Manitoba Dental Association.
The Manitoba Association of Registered Nurses.
The Department of Agriculture.
The Department of Labor
The Union of Municipalities.
The Dominion-Provincial Youth Training Program.
The Manitoba Federation of Agriculture.
The Women's Institutes.
The Red Cross Society.
The Manitoba Hospital Service Association.
The Manitoba Hospital Association.
The St. John's Ambulance Association.
The Imperial Order of Daughters of the Empire.
The Women's Canadian Club.
The Parent-Teacher Association.
The Royal Canadian Mounted Police.

PRINCIPAL STRENGTH AND WEAKNESS OF PUBLIC HEALTH ADMINISTRATION IN MANITOBA

The Department of Health and Public Welfare has strong, capable leadership. The Minister is an efficient administrator in that he follows sound practice in permitting the Deputy Minister to manage the affairs of the Department and plan its program. The Deputy Minister is an extraordinarily capable leader and administrator, a man of real vision who is able to accomplish much more than would seem possible with such limited staff and funds. Professional personnel in key positions is well trained and capable.

Strength. Two features of the generally excellent administrative plan are comparatively unique and seem particularly well adapted to conditions in Manitoba: the combining of health and public welfare under a single administrative department, and the municipal doctor plan in rural areas.

The Cancer Relief and Research Institute and the Canadian Foundation for Preventive Dentistry are providing valuable and important services. There are cordial and in several instances effective cooperative relationships between the official and semi-official agencies administering various phases of the public health program.

On the whole, the Tuberculosis Control program is good except as it applies to Indians. The program for the control of mental disease is particularly well administered and Manitoba can pride itself on having two excellent institutions for the care of the mentally diseased in spite of certain deficiencies.

These are assets of incalculable value. Certain it is that upon them there can and should be founded a more effective province-wide public health service than the present program provides.

Weakness. Among the more important weaknesses are:

1. Local full-time health service is provided for only a small per cent of the population. This is strikingly evident when one considers that of the four full-time health departments, including the city of Winnipeg, only one is outside the Winnipeg metropolitan area and that is in the next largest city of Brandon. There is no full-time local health service for rural Manitoba. Such local health service could be developed on some district basis involving the amalgamation of several municipalities for public health purposes.

2. There is no supervision or consultation-advisory field service for local health departments.

3. There is too much direct service from the Provincial Department of Health and Public Welfare to local areas even including Winnipeg.

4. Except in public health nursing and psychiatric service, there are no understudies for important administrative positions.

5-*a*. Working relationships within the Department of Health and Public Welfare are not as close and effective as they might be.

b. Administrative responsibilities of the Divisions, one to another, and of individuals to each other are not clearly defined.

c. There are no regular staff meetings of the executive personnel of the Department of Health and Public Welfare which accounts in no small measure for the facts mentioned in "*a*" and "*b*".

6. Although the health education activities of the Provincial Department of Health and Public Welfare have reached many organizations and groups, through lectures, moving pictures, exhibits, et cetera, there has not been enough emphasis on teaching individuals, groups, agencies and communities to understand and take part in the solution of their own health problems.

7. Health and welfare field service, as represented by public health nurses and social service workers of the Provincial Department in rural areas, is costly, and there is considerable duplication of effort and travel because of a somewhat specialized rather than a completely generalized field staff.

8. Personnel and funds for the provincial health program and local health activities are insufficient to render the services which the people need and have a right to expect.

9. Salaries are too low to attract or assure the retainment of adequately trained personnel.

10. Although all personnel in the Department of Health and Public Welfare is under Civil Service and there is a retirement plan, the plan does not permit retirement until the age of sixty-five which is too old, at least for public health nurses.

11. While the program for providing public hospital care in Manitoba is in some respects exemplary, it is subject to abuse by both patient and hospital, and lacks adequate supervision.

12. The Manitoba Sanatorium Board is unquestionably providing valuable services in the field of tuberculosis control, but many of its activities are those usually assumed by the official health department, and the Board seems too largely concerned with the Ninette Sanatorium rather than with the broad province-wide tuberculosis control program. (This point is discussed in more detail under Tuberculosis Control.)

13. Although there has been great progress in the control of tuberculosis among the Indians in the last few years, the program is still far from adequate.

14. The municipal-doctor plan, which seems particularly well adapted to present conditions in rural Manitoba, has some deficiencies which need correction.

15. The hospitals for mental diseases are excellent but the number of beds is inadequate, and the Institution for Mental Defectives, while well administered, is totally inadequate and unsuited for the proper segregation of various types of cases.

In establishing these important points, one should mention that nearly all provincial and state health services have developed in much the same manner and had to overcome the same difficulties. Weaknesses are common to the initial period in the growth of public health services in every country. Attention is called to them in no spirit of criticism but merely to emphasize the need for a quite different method of approach, now that the program has passed through its developmental stages.

From this brief description of principal strengths and weaknesses, it is logical to conclude that the future broad basic public health administrative needs of the Province are:

1. The development of a broad, widespread health educational or health informational program, designed to bring about local studies of local health problems and their solution, as the fundamental essential to an understanding of the need for and the value of full-time local health departments.

2. The organization and staffing of these local full-time health departments for which the educational program will have created a demand.

3. Providing supervision and consultation-advisory field service to local full-time health departments which will enable them to supply the

maximum health protection and health promotion services for the people of their respective areas.

4. As full-time local health departments are developed, to withdraw gradually from the present program of providing direct services to local areas, except for emergency and highly technical services which are impracticable and uneconomical of local procurement, as a necessary means of encouraging the development of local full-time health departments.

5. Recognition of the fact that people living in very sparsely settled areas of the Province can not expect to receive beyond the basic provincial governmental services provided anything except emergency health services because of the costliness of such service.

To meet these broad basic needs, it is obvious that a wide variety of services are necessary. These services with suggestions as to how they may be provided will be discussed in succeeding sections of the report. Detailed recommendations will be found in the sections devoted to individual phases of the work, such as Statistics and Records, Tuberculosis Control, et cetera.

MAJOR RECOMMENDATIONS

(AND CERTAIN SUPPLEMENTARY OR COROLLARY RECOMMENDATIONS)

A. *General Public Health.*

It is recommended:

1. THAT THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE, THROUGH ITS DIVISION OF HEALTH EDUCATION AND WITH THE AID OF THE HEALTH EDUCATION COUNCIL (see recommendation under Health and Welfare Education) IMMEDIATELY UNDERTAKE A BROAD-GAUGE PROVINCE-WIDE HEALTH EDUCATION PROGRAM.*

   This should be designed to develop, in as many local communities as possible, a real understanding of the need and value of adequate local health services, to the end that local areas will plan for, and, through their legislative bodies, assist in financing full-time local health departments. This objective can probably best be attained by stimulating and guiding local organizations and groups to study their own health problems and their own facilities for meeting them.

2-*a*. THAT THERE BE ESTABLISHED IN THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE A SECTION OF LOCAL HEALTH AND WELFARE SERVICE, WITH A PHYSICIAN, ESPECIALLY TRAINED AND EXPERIENCED IN PUBLIC HEALTH ADMINISTRATION, AS ITS DIRECTOR.*

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

The Director of Local Health Service, with the advice and counsel of the Minister and Deputy Minister, the Directors of Divisions, and his own field staff, should plan the organization and basic program for local health departments, and assist in obtaining trained personnel for them. Local health service is the most important single service of the entire public health program and the section devoted to it should therefore have its personnel most carefully selected.

b. THAT THE SECTION OF LOCAL HEALTH SERVICE HAVE, IN ADDITION TO ITS DIRECTOR, A CONSULTATION-ADVISORY FIELD STAFF WHOSE FUNCTION SHOULD BE TO PROVIDE PERIODIC PERSONAL CONSULTATION-ADVISORY SERVICE, WITH SOME SUPERVISORY FUNCTIONS, TO LOCAL HEALTH DEPARTMENTS.

This field staff should have no central office functions other than to make reports and confer periodically with the Director of Local Health Service and directors of other bureaus and divisions. The field staff, as its name implies, should be in the field constantly, rendering service to local health departments. Personnel of this staff should, insofar as possible, be loaned to the Section of Local Health and Welfare Service by the various bureaus and divisions of the Department.

3. THAT ONE ESPECIALLY WELL-PLANNED AND WELL-STAFFED FULL-TIME HEALTH AND WELFARE UNIT, COVERING FROM FOUR TO SEVEN MUNICIPALITIES, BE ESTABLISHED AS A DEMONSTRATION OF WHAT CAN BE DONE IN PROVIDING ADEQUATE LOCAL HEALTH AND WELFARE SERVICES, AND BE USED AS A TRAINING CENTER FOR PUBLIC HEALTH AND WELFARE PERSONNEL.*

4. THAT FAR LARGER APPROPRIATIONS BE MADE AVAILABLE FOR THE SUPPORT AND DEVELOPMENT OF FULL-TIME LOCAL HEALTH DEPARTMENTS.*

5. THAT A SPECIAL APPROPRIATION BE MADE FOR TRAINING PUBLIC HEALTH PERSONNEL.

6. THAT, IN ADDITION TO PROVINCIAL APPROPRIATIONS FOR DEVELOPING FULL-TIME LOCAL HEALTH DEPARTMENTS AND FOR TRAINING PUBLIC HEALTH PERSONNEL, AN EFFORT BE MADE TO OBTAIN FEDERAL APPROPRIATIONS FOR THESE PURPOSES.

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

7. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE ADOPT THE PLAN OF ORGANIZATION DEVELOPED IN THE CHART ON PAGE 26A, AS A MEANS OF:

   (*a*) BRINGING ABOUT A MORE EFFECTIVE METHOD OF ADMINISTRATION BY PLACING EXECUTIVE RESPONSIBILITY IN THE HANDS OF A COMPARATIVELY FEW WELL-TRAINED INDIVIDUALS;

   (*b*) DEFINING ADMINISTRATIVE LINES OF RESPONSIBILITY THROUGHOUT THE DEPARTMENT;

   (*c*) PROVIDING A PLAN FOR PROMOTING PARTICULARLY CAPABLE ADMINISTRATORS OR FOR EMPLOYING NEW WELL-QUALIFIED ADMINISTRATORS IF NONE ARE AVAILABLE IN ANY GIVEN SECTION OF THE DEPARTMENT.

8. THAT THE DEPARTMENT TAKE IMMEDIATE STEPS TO MAKE AVAILABLE YOUNG, WELL-QUALIFIED ASSISTANTS TO PERSONS IN EXECUTIVE POSITIONS.*

   With the exception of public health nursing and psychiatric service, all divisions are in need of such assistants. Most in need of an assistant, well-trained and experienced in public health laboratory methods, is the Director of Laboratories.

9. THAT PRESENT SALARY SCHEDULES BE REVISED UPWARD AS A MEANS OF RETAINING TRAINED PERSONNEL AND ATTRACTING WELL-TRAINED PERSONS TO POSITIONS AS ASSISTANTS TO DIRECTORS OF DIVISIONS.

   (A specific salary schedule has been recommended to the Minister and Deputy Minister of Health and Public Welfare, and the Civil Service Commissioner.)

10. THAT, BECAUSE OF THE PRESENT EMERGENCY, THE PROVINCIAL DEPARMENT OF HEALTH AND PUBLIC WELFARE AND ALL OTHER PUBLIC HEALTH AGENCIES CONSIDER THE POSSIBILITY OF TEMPORARILY CHANGING THE EMPHASIS ON SERVICE FROM PRENATAL AND EARLY AGE GROUPS TO THOSE OF HIGH SCHOOL AND EARLY ADULT YEARS.

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

Records indicate that in both Canada and the United States large numbers of young men are being found physically unfit for military service. Many of the conditions which make them unfit are or might have been remediable. If this be true, with the prospect of many of our present high school students being called to service in the next few years, it might be wise to concentrate efforts for the time being on young men and women of high school age with a view to having as many as possible physically able to serve the country.

11. THAT, IN VIEW OF THE EXPENSE INVOLVED IN SENDING SEVERAL PERSONS TO SPARSELY SETTLED AREAS TO RENDER SEPARATE BUT RELATED SERVICES WHICH CONSTITUTE LEGAL RESPONSIBILITIES OF THE DEPARTMENT, THE DEPARTMENT TAKE IMMEDIATE STEPS TO TRAIN A GENERALIZED FIELD STAFF IN PUBLIC HEALTH NURSING AND WELFARE FOR OUTLYING RURAL DISTRICTS.

In order to make possible a closer and more effective relation between the chief executive of the Department of Health and Public Welfare and other executive personnel of the Department, and to insure that all the records of the Department, particularly mortality and morbidity statistics, shall be deposited and maintained in one place, it is recommended:

12. THAT A NEW BUILDING BE ERECTED ON THE GROUNDS OF THE PRESENT HEALTH AND WELFARE BUILDING TO HOUSE THE GENERAL ADMINISTRATIVE OFFICES OF THE DEPARTMENT, THE DIVISION OF VITAL STATISTICS, HEREAFTER TO BE KNOWN AS THE BUREAU OF STATISTICS AND RECORDS, AND IF POSSIBLE THE BUREAU OF LABORATORIES.

Concerning tuberculosis control and prevention, it is recommended:

13. THAT WHEREVER FULL-TIME HEALTH UNITS OR DEPARTMENTS ARE IN EXISTENCE OR ARE ESTABLISHED IN THE FUTURE, SUCH LOCAL HEALTH DEPARTMENTS ASSUME THE RESPONSIBILITY FOR THEIR OWN TUBERCULOSIS CONTROL AND PREVENTION PROGRAMS, WITH ONLY SUCH CONSULTATION, ADVISORY OR OTHER SERVICES FROM THE MANITOBA TUBERCULOSIS CONTROL COMMISSION AS MAY BE NECESSARY FOR THE EFFECTIVE FUNCTIONING OF SUCH PROGRAMS.

14-*a*. THAT THE MANITOBA SANATORIUM BOARD BE ABOLISHED, AND, IN ITS PLACE, THE LIEUTENANT-GOVERNOR-IN-COUNCIL APPOINT A MANITOBA TUBERCULOSIS CONTROL COMMISSION TO BE COMPOSED OF THE NINE STATUTORY MEMBERS NOW PRESCRIBED FOR THE SANATORIUM BOARD, AND FIFTEEN OTHER MEMBERS TO BE APPOINTED FOR THREE-YEAR TERMS.*

At the expiration of a three year term an appointed member may be eligible for re-election for a second three year term, but shall not serve for more than two consecutive three year terms. After the interim of a year, a member again becomes eligible for election.

b. THAT THE MANITOBA TUBERCULOSIS CONTROL COMMISSION EMPLOY AS DIRECTOR A FULL-TIME PHYSICIAN, WELL-TRAINED AND EXPERIENCED IN TUBERCULOSIS CONTROL, AND SUCH OTHER PERSONNEL AS MAY BE NECESSARY, NONE OF THESE TO BE EMPLOYED BY, OR HAVE ANY SPECIFIC ADMINISTRATIVE DUTIES IN ANY TUBERCULOSIS INSTITUTION EXCEPT THE TUBERCULOSIS CENTRAL CLINIC.

c. THAT THE BASIC FUNCTIONS OF THE MANITOBA TUBERCULOSIS CONTROL COMMISSION BE:

1. TO CONDUCT THE CENTRAL TUBERCULOSIS CLINIC IN COOPERATION WITH THE TUBERCULOSIS BUREAU OF THE WINNIPEG CITY HEALTH DEPARTMENT AND THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE;

2. TO CONDUCT THE TUBERCULOSIS TRAVELING CLINICS;

3. TO DEVELOP THROUGHOUT THE PROVINCE AN EDUCATIONAL PROGRAM IN BEHALF OF TUBERCULOSIS CONTROL AND PREVENTION;

4. TO RENDER CONSULTATION AND SUPERVISORY SERVICES TO INSTITUTIONS CARING FOR THE TUBERCULOUS THROUGHOUT THE PROVINCE;

5. TO SET UP MINIMUM UNIFORM STANDARDS FOR THE CARE OF THE TUBERCULOUS IN ALL

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

TUBERCULOSIS INSTITUTIONS AND TO PLAN WITH SUCH INSTITUTIONS FOR THE MOST EFFECTIVE USE OF AVAILABLE FACILITIES.

*d. THAT THE MEMBERS OF THE TUBERCULOSIS CONTROL COMMISSION FUNCTION AS THE JUDICIARY, ADVISORY, POLICY-FORMING BRANCH OF THE COMMISSION, AND THE MEDICAL DIRECTOR, WHOSE TITLE MIGHT WELL BE TUBERCULOSIS COMPTROLLER, AND HIS STAFF, FUNCTION AS THE EXECUTIVE BRANCH.

15. THAT A NEW BOARD, DISTINCT AND APART FROM THE TUBERCULOSIS CONTROL COMMISSION, BE APPOINTED BY THE LIEUTENANT-GOVERNOR-IN-COUNCIL TO ACT AS THE JUDICIARY, ADVISORY, POLICY-FORMING AGENCY FOR THE NINETTE SANATORIUM.

16. THAT THE NUMBER OF BEDS AT THE CENTRAL TUBERCULOSIS CLINIC BE REDUCED FROM 50 TO LESS THAN 25 AND THAT NO CHILDREN BE CARED FOR AT THAT INSTITUTION.

17. THAT ALL WINNIPEG CASES OF TUBERCULOSIS BE ADMITTED TO HOSPITAL CARE AT THE KING EDWARD HOSPITAL.

Those cases which might benefit by reasonably prolonged care at either St. Boniface Sanatorium or the Ninette Sanatorium should be transferred to these institutions. Winnipeg cases requiring major surgery probably should have such surgery at the King Edward Hospital. Graduation from the King Edward Hospital should be made upon recommendation of the Tuberculosis Comptroller.

18. THAT THE MUNICIPAL TUBERCULOSIS TAX LEVY BE REVIEWED AND MADE ADEQUATE TO COVER THE COSTS OF TUBERCULOSIS CONTROL.*

The foregoing are considered major recommendations in the field of general public health. The following are, in many instances, dependent upon the foregoing recommendations, and may therefore be considered as supplementary or corollary. It is recommended:

(a) THAT, AS FULL-TIME LOCAL HEALTH DEPARTMENTS ARE ORGANIZED, THE DEPARTMENT OF

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

HEALTH AND PUBLIC WELFARE DISCONTINUE ITS DIRECT SERVICES TO LOCAL AREAS, EXCEPT FOR EMERGENCY AND HIGHLY TECHNICAL SERVICES.

This recommendation is made because supplying direct services from the Central Office is costly and relatively ineffective and in many instances acts as a deterrent to the development of adequate local health service.

(*b*) THAT, AS A COROLLARY TO THE ABOVE, THE AGENCIES ADMINISTERING THE PROVINCIAL PUBLIC HEALTH PROGRAM STATE FRANKLY THAT IT IS TOO COSTLY AND INEFFICIENT TO SUPPLY SERVICES FROM THE PROVINCE TO THE SPARSELY SETTLED UNORGANIZED AND DISORGANIZED AREAS EXCEPT FOR EMERGENCY AND HIGHLY TECHNICAL SERVICES.

Persons who live in very sparsely settled areas, unable to conduct their own governmental functions, pay far less in taxes than those in populous areas, and therefore must expect the minimum in service from the Provincial Government and other provincial agencies.

(*c*) THAT, AS FULL-TIME LOCAL HEALTH DEPARTMENTS ARE ESTABLISHED, CONSIDERATION BE GIVEN TO COMBINING IN SUCH DEPARTMENTS, HEALTH, WELFARE AND PUBLIC MEDICAL AND DENTAL CARE PROGRAMS.

(*d*) THAT, IN ORDER TO DEVELOP MORE EFFECTIVE WORKING RELATIONS BETWEEN THE VARIOUS BUREAUS AND DIVISIONS OF THE DEPARTMENT, BUILD AN ESPRIT DE CORPS WHICH WILL RESULT IN MORE INTELLIGENT AND ENTHUSIASTIC WORK ON THE PART OF THE INDIVIDUAL, AND KEEP THE ENTIRE PERSONNEL OF THE DEPARTMENT CURRENTLY INFORMED REGARDING PLANS AND ACTIVITIES, THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE HOLD REGULAR STAFF MEETINGS AT LEAST EVERY TWO WEEKS.

A definite day, time and place should be designated so that all can plan to attend. All executive personnel—section, bureau and divisional directors of both the health and welfare branches of the Department—should be expected to attend these meetings regularly and take an active part in the discussion. Occasionally when topics of particular interest or importance are to be discussed, all members of the Department should be invited.

(*e*) THAT THE DIVISION OF HEALTH EDUCATION, IN KEEPING WITH THE POLICY RECOMMENDED

FOR THE DEPARTMENT AS A WHOLE, CHANGE ITS PROGRAM OF RENDERING DIRECT SERVICE, TO ONE OF ASSISTING AGENCIES AND GROUPS TO DEFINE PROBLEMS AND PLAN THEIR SOLUTION. IN THIS, THE DIVISION OF HEALTH EDUCATION SHOULD COOPERATE WITH THE HEALTH EDUCATION COUNCIL.

(See Section on Health Education.)

(*f*) THAT FUNDS AND PERSONNEL OF THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE BE INCREASED SO THAT THE DEPARTMENT MAY RENDER MORE COMPREHENSIVE AND EFFECTIVE SERVICES THAN ARE NOW POSSIBLE.

More adequate grants for local health service, a far more extensive program of maternal and child health, additional trained personnel for laboratory work, and a staff to provide consultation and supervisory services for local health departments, are among the more important needs.

(*g*) THAT, SINCE THE RECORDS OF THE DEPARTMENT OF HEALTH ARE NOT UNIFORM AND IN SOME INSTANCES NOT SATISFACTORY, THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE REQUEST ASSISTANCE FROM THE COMMITTEE ON RECORDS OF THE STATE AND PROVINCIAL HEALTH AUTHORITIES IN DEVELOPING AND STANDARDIZING ITS RECORD SYSTEM.

(*h*) THAT A REGULATION BE PASSED MAKING MANDATORY THE INSTALLATION OF A PROPHYLACTIC AGENT IN THE EYES OF THE NEWBORN BY PHYSICIAN, MIDWIFE OR OTHER PERSON ATTENDING THE DELIVERY.

B. *Municipal Physicians.*

As an additional means of providing more satisfactory local health services in areas where full-time local health departments seem unfeasible, and to further implement local health service in areas having full-time health departments or in which such departments may be developed, it is recommended:

19. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE INAUGURATE AN EDUCATIONAL PROGRAM DESIGNED TO ENCOURAGE MUNICIPALITIES IN RURAL AREAS TO EMPLOY MUNICIPAL DOCTORS.

20. THAT THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE CONDUCT, ON A REGIONAL BASIS, SHORT COURSES IN PREVENTIVE MEDICINE AND PUBLIC HEALTH FOR MUNICIPAL DOCTORS.*

21. THAT CONTRACTS BETWEEN MUNICIPALITIES AND PHYSICIANS BE REVISED TO FURNISH MORE ADEQUATE PROTECTION FOR THE PHYSICIAN; ALL CONTRACTS SHOULD PROVIDE: (*a*) A BASIC MINIMUM SALARY; (*b*) SPECIFIC OFFICE HOURS FOR THE PHYSICIAN; (*c*) A SPECIFIC PROCEDURE FOR OBTAINING AND PAYING FOR MAJOR SURGERY, PROBABLY BY A PHYSICIAN OR PHYSICIANS OTHER THAN THE MUNICIPAL DOCTOR; AND (*d*) THE RIGHT OF APPEAL IN ANY DISPUTE OR IN ANY ACTION BROUGHT OR CONTEMPLATED BY THE MUNICIPALITY AGAINST THE MUNICIPAL DOCTOR, TO A COMMITTEE OF THREE TO BE COMPOSED OF THE DEPUTY MINISTER OF HEALTH, OR HIS REPRESENTATIVE, AND ONE REPRESENTATIVE FROM THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION, AND FROM THE MUNICIPALTY, THE DECISION OF THIS COMMITTEE IN THE ADJUDICATION OF SUCH CASES TO BE FINAL.*

C. *Public Welfare.*

In order to bring about a more effective and closely knit functioning of public welfare and health, it is recommended:

22-*a*. THAT THE WELFARE SUPERVISION BOARD BE ESSSENTIALLY AN ADVISORY, JUDICIARY, POLICY-FORMING GROUP FOR THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE, PARALLELING THE FUNCTIONS OF THE ADVISORY BOARD OF HEALTH.

b. THAT THE MINISTER OF HEALTH AND PUBLIC WELFARE BE AN EX OFFICIO MEMBER OF THE WELFARE SUPERVISION BOARD AND THE DEPUTY MINISTER ITS EXECUTIVE OFFICER.*

23-*a*. THAT THE CHILD WELFARE BOARD BE MADE A STANDING COMMITTEE OF THE WELFARE SUPERVISION BOARD.

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*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

b. THAT THE CHILD WELFARE BOARD BE REORGANIZED SO AS TO PROVIDE ROTATING MEMBERSHIP INSTEAD OF ITS PRESENT STATIC MEMBERSHIP.

c. THAT THE FUNCTIONS OF THE CHILD WELFARE BOARD, HEREAFTER TO BE A STANDING COMMITTEE OF THE WELFARE SUPERVISION BOARD, BE ESSENTIALLY ADVISORY, JUDICIARY AND POLICY-FORMING.*

Only the most important and significant questions and serious complaints should be referred to this Board for decision.

D. *General Hospital Care.*

With respect to hospital care at public expense, it is recommended:

24. THAT ALL HOSPITALS RECEIVING CASES, FOR WHICH THE MUNICIPALITY OR THE PROVINCE IS EXPECTED TO PAY, BE REQUIRED TO OBTAIN A WRITTEN STATEMENT FROM THE MUNICIPALITY OR PROVINCE ACKNOWLEDGING RESPONSIBILITY FOR PAYMENT *BEFORE* THE PATIENT IS ADMITTED TO THE HOSPITAL; AND THAT FAILURE ON THE PART OF THE HOSPITAL TO OBTAIN THIS WRITTEN AUTHORIZATION, SHALL, EXCEPT IN EMERGENCIES, ABSOLVE THE MUNICIPALITY OR PROVINCE FROM ALL FINANCIAL RESPONSIBILITY FOR SUCH CARE.*

25. THAT THE PRESENT WORDING OF THE CLAUSE IN THE HOSPITAL AID ACT, WHICH PERMITS HOSPITALIZATION WITHOUT ANY AUTHORIZATION FROM THE MUNICIPALITY OR THE PROVINCE, BE CHANGED TO READ:

"NO PATIENT SHALL BE ADMITTED TO HOSPITAL CARE AT PUBLIC EXPENSE WITHOUT THE WRITTEN AUTHORIZATION OF THE MUNICIPALITY OR PROVINCE UNLESS A PHYSICIAN CERTIFIES THAT THE PATIENT'S CONDITION IS SUCH THAT FAILURE TO HOSPITALIZE IMMEDIATELY MAY SERIOUSLY ENDANGER THE PATIENT'S LIFE."*

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

In such an emergency, the hospital shall notify the municipality or province of the admission of the case within twenty-four hours of admission.

26. THAT PERSONS THROUGHOUT THE PROVINCE BE PERMITTED TO USE THE OUTPATIENT SERVICES OF THE WINNIPEG HOSPITALS PROVIDED SUCH OUTPATIENT CARE IS RECOMMENDED BY THE MEDICAL HEALTH OFFICER OR OTHER AUTHORIZED PHYSICIAN, AND IS FURTHER AUTHORIZED IN WRITING BY THE MUNICIPALITY IN WHICH THE PATIENT IS A RESIDENT, OR BY THE PROVINCE IF THE PATIENT RESIDES IN UNORGANIZED OR DISORGANIZED TERRITORY.

Authorization for such care should include the agreement to pay at the rate of 25 cents for each visit to the Outpatient Department plus the cost of special services, such as X-ray, basal metabolism tests, special laboratory tests, et cetera. Charges for such services should be listed by the hospital and sent to all medical health officers, physicians and municipal officials.

27-*a*. THAT THE LIEUTENANT-GOVERNOR-IN-COUNCIL APPOINT A HOSPITAL COMMISSION TO BE COMPOSED OF ONE REPRESENTATIVE FROM THE UNION OF MUNICIPALITIES, ONE FROM THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION, ONE FROM THE MANITOBA DENTAL ASSOCIATION, ONE FROM THE MANITOBA ASSOCIATION OF REGISTERED NURSES, ONE FROM THE PROVINCIAL GOVERNMENT, AND ONE HOSPITAL REPRESENTATIVE PREFERABLY FROM OUTSIDE MANITOBA.*

It is suggested that the hospital representative be appointed from outside the Province because if he were chosen from Manitoba, he would necessarily be associated with some hospital in the Province and might therefore be accused of bias.

b. THAT THE HOSPITAL COMMISSION MAKE A STUDY OF ALL HOSPITALS IN MANITOBA AND INCLUDE THE CONSIDERATION OF BED CAPACITY, BED OCCUPANCY, COSTS, MEDICAL, DENTAL AND NURSING FACILITIES, EDUCATIONAL FACILITIES, AND EQUIPMENT AND FACILITIES FOR PROVIDING VARIOUS TYPES OF SPECIAL CARE.*

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

c. THAT, ON THE BASIS OF THIS STUDY, THE HOSPITAL COMMISSION GRADE ALL HOSPITALS IN THE PROVINCE AND RECOMMEND TO THE LIEUTENANT-GOVERNOR-IN-COUNCIL SPECIFIC PER DIEM RATES FOR PUBLIC WARD CASES IN ACCORDANCE WITH THE GRADE OBTAINED BY EACH HOSPITAL.*

For example, Grade A hospitals might be paid $2.00 per diem, Grade B hospitals $1.50, et cetera. Grades probably should range from A through E, D being the grade which will receive the lowest per diem payment, and E designated as "Not at present meeting minimum requirements for any per diem payments by municipal or provincial governments". In making the study and assigning grades to hospitals, the Hospital Commission should take into consideration type and extent of available medical and nursing services. For example, Grade A hospitals would doubtless be approved for all types of service, Grade B would perhaps be approved for all except certain special services, Grade C might be approved except for major surgery, and Grade D for only relatively simple types of care.

d. THAT THE HOSPITAL COMMISSION ALSO SPECIFY THE REQUISITES FOR ADMISSION TO PUBLIC WARD CARE AND THE REQUIREMENT FOR ACKNOWLEDGMENT OF RESPONSIBILITY FOR SUCH CARE FROM THE MUNICIPALITY AND/OR THE PROVINCIAL GOVERNMENT WHICH IS EXPECTED TO BEAR THE EXPENSE OF SUCH CARE.*

E. *Mental Disease and Mental Hygiene.*

In order to provide more adequate facilities for the care of mental diseases and mental defectives, it is recommended:

28. THAT AN INSTITUTION OF APPROXIMATELY 250 BEDS FOR CUSTODIAL CARE BE ESTABLISHED, PROBABLY AT PORTAGE LA PRAIRIE, TO WHICH SENILE CASES FROM BOTH THE HOSPITALS FOR MENTAL DISEASES AND THE SCHOOL FOR MENTAL DEFECTIVES MAY BE TRANSFERRED.*

Unquestionably there is need for more beds for mental disease and mental defectives and transferring cases which need only custodial care to this institution will free 250 beds for mental cases and mental defectives—probably about 100 beds at Brandon, 100 in the Manitoba School for Mentally Defective Persons, and 50 at Selkirk.

29. THAT A UNIT FOR INFIRMARY PATIENTS BE ESTABLISHED AT SELKIRK, BY REARRANGE-

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

MENT, RECONSTRUCTION, OR IF NECESSARY BY NEW CONSTRUCTION, WITH FACILITIES FOR ADEQUATE SEGREGATION OF TUBERCULOSIS PATIENTS.

At present there is a "bottle neck" in the reception or diagnostic wards at all three mental disease institutions—the Psychopathic Hospital in Winnipeg and those in Brandon and Selkirk. This is due to lack of beds for mental patients, particularly chronics, which makes it necessary to retain in the psychopathic treatment wards patients who are not hopeful cases and who would be transferred to mental disease beds if any were available. The foregoing recommendations are intended to make possible more effective use of psychiatric treatment facilities for hopeful cases and to improve the situation at the Manitoba School for Mentally Defective Persons.

30. THAT MENTAL HYGIENE ACTIVITIES AT THE PSYCHOPATHIC HOSPITAL AND THE INSTITUTION AT BRANDON BE INCREASED SUBSTANTIALLY AND THAT SPECIFIC APPROPRIATIONS BE GRANTED FOR MENTAL HYGIENE.*

This is particularly important since it represents the preventive approach to the mental disease problem.

31. THAT, AT THE EARLIEST POSSIBLE MOMENT, THE MANITOBA SCHOOL FOR MENTALLY DEFECTIVE PERSONS SEGREGATE ITS CASES ACCORDING TO THE DEGREE OF MENTAL DEFECTIVENESS, SEPARATE CHILDREN FROM ADULTS, AND IN THE FUTURE ADMIT CHILDREN RATHER THAN ADULTS.

*Recommendations starred are considered basic and should be undertaken immediately. Others, which may be equally important, are largely dependent upon the basic recommendations.

It is realized that the recommendations made in the foregoing pages and elsewhere in this report can not all be put into effect immediately. Some are relatively simple of achievement while others may require considerable time. Regardless of possible difficulties, it is to be hoped that the agencies concerned will immediately set in motion plans for carrying out these suggestions.

Certain steps will require additional funds. While the Provincial Government recognizes its responsibility for assisting local areas to provide needed public health services, the federal government apparently assumes a very limited responsibility toward the provinces in this respect. Dominion aid to Manitoba for public health services is at present confined to supplying arsenicals for syphilis treatment and to supporting the work of the Department of Indian Affairs.

Recently this question has been freely discussed by public health and other government officials throughout the provinces. It is greatly to be hoped that the recommendations of the Dominion Council of Health to the Department of Pensions and National Health will be put into effect. Compliance with these recommendations on the part of the Dominion government would aid tremendously in bringing about more effective public health service throughout the Province.

The following sections of this report are devoted to the detailed organization and functions of health and welfare work in Manitoba.

THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

PLAN OF ORGANIZATION

The organization chart for the Department of Health and Public Welfare, as contained in the 1939 Annual Report of the Department, is excellent in its general provisions but the divisional plan under the major subdivisions of Health and Welfare seems unduly complicated, and does not lend itself to as effective administration as would be possible with a somewhat simpler form of organization in which administrative authority is placed in the hands of a smaller number of competent executives.

In order to define administrative responsibilities more clearly and concentrate major administrative functions in the hands of a few well-chosen executives, it is recommended:

> THAT THE PLAN OF ORGANIZATION AS PRESENTED IN THE CHART ON PAGE 26A BE ADOPTED.

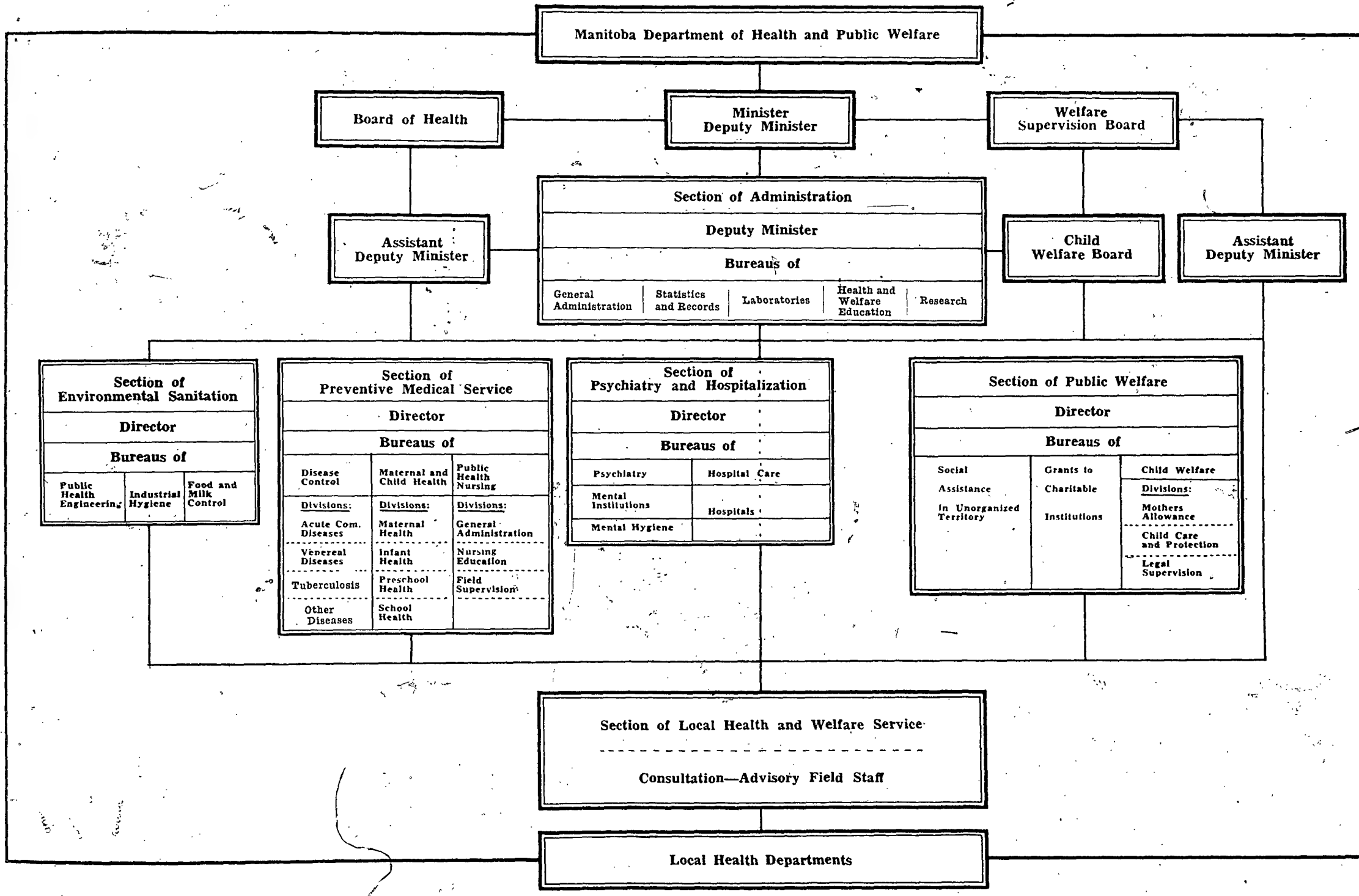
Under this plan the Department would have, in addition to the Minister and Deputy Minister, two qualified assistants to the Deputy Minister, one in charge of Health, the other in charge of Welfare.

The Assistant in Health would have general supervision over the entire health program and also direct supervision over the Section on Administration including the Bureaus of General Administration, Statistics and Records, Laboratories, and Health and Welfare Education.

In addition, there would be four directors of sections; the Director of the Section of Preventive Medical Services (including the Bureaus of Disease Prevention and Control, Maternal and Child Health, and Public Health Nursing); the Director of the Section on Environmental Sanitation (including the Bureaus of Public Health Engineering, Industrial Hygiene, and Milk and Food Control); the Director of the Section on Psychiatry and Hospitalization (including the Bureaus of Psychiatry and Hospital Care); and the Director of Local Health Service who would be in charge of the Consultation-Advisory Field Staff.

The Assistant to the Deputy Minister in charge of Welfare would be supported by the Directors of the three Bureaus of Social Assistance, Grants to Charitable Institutions, and Child Welfare.

If this plan is put into operation, the Deputy Minister, as the executive director of the Department of Health and Public Welfare, could administer the work of the entire Department through two individuals—his assistants in charge of Health and Welfare. It would seem desirable, however, to administer the Department


Manitoba Department of Health and Public Welfare
Board of Health
Minister
Deputy Minister
Welfare
Supervision Board
Assistant
Deputy Minister
Section of Administration
Deputy Minister
Bureaus of
General Administration
Statistics and Records
Laboratories
Health and Welfare Education
Research
Child
Welfare Board
Assistant
Deputy Minister
Section of
Environmental Sanitation
Director
Bureaus of
Public Health Engineering
Industrial Hygiene
Food and Milk Control
Section of
Preventive Medical Service
Director
Bureaus of
Disease Control
Maternal and Child Health
Public Health Nursing
Divisions:
Acute Com. Diseases
Venereal Diseases
Tuberculosis
Other Diseases
Divisions:
Maternal Health
Infant Health
Preschool Health
School Health
Divisions:
General Administration
Nursing Education
Field Supervision
Section of
Psychiatry and Hospitalization
Director
Bureaus of
Psychiatry
Hospital Care
Mental Institutions
Hospitals
Mental Hygiene
Section of Public Welfare
Director
Bureaus of
Social Assistance in Unorganized Territory
Grants to Charitable Institutions
Child Welfare
Divisions:
Mothers Allowance
Child Care and Protection
Legal Supervision
Section of Local Health and Welfare Service
Consultation—Advisory Field Staff
Local Health Departments

through six individuals—his two assistants and the four Section Directors.

Although obviously simplifying administrative responsibilities, this plan might seem at first glance to involve the addition of several executive persons to the staff of the Department. There is in this proposed plan one definitely new position, and a very important one, that of Director of Local Health Services. With this exception the plan is flexible in that it permits either the promotion of present or the employment of new personnel. For example, if in the Section on Administration there is no bureau director with sufficient administrative ability to warrant his promotion to the position of Director of the Section, then the selection of a new person would be indicated. If, on the other hand, one of the bureau directors did have exceptional administrative ability, then he might well be promoted to the position of Director of the Section and, if the situation warranted, also retain the directorship of the bureau from which he was promoted.

The several advantages of this plan of organization are:

(*a*) It enables the Deputy Minister of Health and Public Welfare to administer his entire Department through a small number of executives;

(*b*) It avoids a large number of more or less independent administrative units and enables the Deputy Minister to correlate the work of his Department efficiently;

(*c*) It defines clearly the lines of responsibility among the directors of the several sections and bureaus of the Department;

(*d*) It centralizes the direction of bureaus having close inter-relationships in a single section-director who in turn interprets the programs and needs of these bureaus to the Deputy Minister;

(*e*) It provides a clear cut channel to the field through the Section of Local Health and Welfare Service for the policies and techniques worked out by the various bureaus.

SALARIES

As previously stated, the Provincial Governmental plan of having a Minister who is the political, advisory, judicial head of the Department, and a Deputy Minister who is the professionally qualified executive head, and who has Civil Service rating has many important advantages. However, as practised in Manitoba, there is one very serious drawback, and that is that the Minister's salary sets the scale for all other employees in the Department. The Provincial Government does not approve any Deputy receiving as much as the basic salary of the Minister who, of course, receives an additional sum, the usual "indemnity" paid him as a member of the legislature. This means that the Deputy Minister can not receive a salary in any way commensurate with the training and experience required for the position or with the responsibilities

which he is expected to assume. Further, the inadequate salary of the Deputy Minister depresses the salaries of other personnel in the Department. This attitude is so detrimental that it probably outweighs all the favorable aspects of the situation. Salaries of professionally trained people are shamefully low. Think of a physician with a diploma in public health working for a salary of $200.00 per month, or of a director of public health nurses, with over twenty-five years of distinguished service, receiving even less.

Unless this unfortunate condition can be remedied when normal times return, the Province of Manitoba will surely lose some of its best qualified professional personnel to other provinces, to the United States, or to private enterprise.

In considering this issue (important because if effective governmental services are to be retained, reasonable salaries must be paid), three major points should be borne in mind. First, Ministers are appointed for definite, relatively short periods. They are not required to have any special qualifications; theirs are not career positions, and furthermore, they do not expect to make their livelihood completely through the position. Second, the Deputy Minister and other professional personnel in the Department are career people; they expect to earn their living in the positions or professions to which they are devoting themselves. Third, one continually hears the statement that this is essentially a farm government and the farmer feels that governmental expenses including salaries must be kept to an absolute minimum. While sympathetic to this attitude, one may yet feel that the conclusion is not justified. The farmer constitutes the very backbone of life on the North American Continent. He has often had and is having a difficult time. The farmer is entitled to and should have the allegiance and unstinted support of all people, for our very lives depend upon his ability to carry on successfully. Nevertheless, the farmer frequently has an unjustified attitude toward money based on the peculiar circumstances of his calling. A sum of $300.00 or $400.00 a month may seem to the farmer a munificent salary because he does not need to pay cash for as many necessities as the person on salary who must purchase everything. If this difference could be clearly and universally understood, it would no doubt produce a different reaction toward salaries because the farmer is just as anxious as anyone to have effective governmental services.

It is recommended:

THAT, AS A NECESSARY MEANS OF INSURING THE RETENTION OF TRAINED PERSONNEL, THE PRESENT SALARY SCHEDULE BE REVISED UPWARD AND THAT THE NEW SCHEDULE BE

BASED UPON TRAINING, EXPERIENCE AND THE RESPONSIBILITIES OF THE POSITION.

(A proposed detailed salary schedule has been presented to the Minister and Deputy Minister of Health and Public Welfare and to the Civil Service Commission.)

Salary schedules should provide for annual increases. However, such increases should not be automatic but should be granted only on demonstrated merit.

Persons with more than the minimum qualifications for a given position should be employed at more than the minimum salary.

Travel allowances should be based not only on distance traveled but on the relative difficulty (and cost) of such travel. Allowances might vary from $25.00 per month, in small and easily traveled areas, to $75.00 per month in large areas where travel is difficult.

All persons required to purchase and use their own cars while on duty should be paid a minimum of $25.00 per month to cover depreciation.

EXPENDITURES AND PERSONNEL

Expenditures. It is frequently said that "Health is a purchasable commodity." Therefore, as larger sums of money are allocated to well-administered health departments, proportionate improvement should be expected in the health of the people. Conservation of life and health is surely ample and gratifying compensation for the comparatively small sums expended on health activities. Health services can not develop unless sufficient money is provided. The cost of preventive services for large groups of people is much less than the monies required to diagnose and treat those suffering from preventable disease.

Estimated expenditures of the Manitoba Department of Health and Public Welfare, for the present fiscal year ending April 30, 1942, are given in Tables 1-A, B, C, D, and E.

The most notable fact brought out by these tables is to be found in Table 1-E which shows that of every provincial tax dollar expended for health, welfare, and mental and general hospital care, only ten cents is spent for public health. The enormous cost of welfare and hospital care as compared with the expenditures for public health is strikingly evident. This table also helps to bear out the statement made elsewhere in this report that Manitoba has been conservative in its expenditures for public health, and perhaps unnecessarily extravagant in its provision for hospital care at public expense. This statement does not apply to mental disease or the institutional care of tuberculosis but rather to general hospital care, the privileges of which, it is believed, are being considerably abused.

Table 1-A.

PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Expenditure Estimates for year ending April 30, 1942

A. Public Health

	Salaries	Supplies, Expenses, Equipment & Rentals	Travel	Biological Products, Drugs, etc.	Direct Financial Aid	Total	Per Cent	Cents per Capita
Executive Office	$ 7,666.00					$ 7,666.00	3.1	1.1
Acute Com. Disease	4,604.50	$ 8,700.00xx	$ 800.00	$23,000.00		37,104.50	15.0	5.3
Venereal Disease	4,600.50	900.00	400.00	21,000.00		26,900.50	10.8	3.8
Maternal and Child Health	1,101.75	1,050.00	250.00			2,401.75	1.0	0.3
Public Health Nursing	57,035.00	3,200.00	15,400.00			75,635.00	30.5	10.8
General Sanitation	7,815.75	1,200.00	3,500.00			12,515.75	5.0	1.8
Food and Milk Control	7,011.75	500.00	1,500.00			9,011.75	3.6	1.3
Grant to Cancer Relief and Research					4,500.00	4,500.00	1.8	0.6
Health Education	7,095.75	1,900.00	500.00			9,495.75	3.8	1.4
Provincial Laboratory	16,320.72	3,100.00				19,420.72	7.8	2.8
Vital Statistics	12,906.00	5,400.00				18,306.00	7.4	2.6
Total for Health (Central Office)	$126,157.72	$25,950.00	$22,350.00	$44,000.00	$4,500.00	$222,957.72	89.8	31.8

x Per capita is based on an estimated population of 700,000.

xx This fund is flexible and may be used for salaries, supplies, etc., as needed in epidemics.

Table 1-A (Cont'd)

PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Expenditure Estimates for year ending April 30, 1942

A. Public Health (Cont'd)

	Salaries	Supplies, Expenses, Equipment & Renewals	Travel	Biological Products, Drugs, etc.	Direct Financial Aid	Total	Per Cent	Cents per Capita
Aid to Local Health Services								
Health Units					$18,200.00	$ 18,200.00	7.1	2.6
Health Officers Unorganized Territory					7,000.00	7,000.00	2.8	1.0
Total Aid to Local Health					$25,200.00	$ 25,200.00	10.2	3.6
GRAND TOTAL FOR HEALTH	$126,157.72	$25,950.00	$22,350.00	$11,000.00	$29,700.00	$248,157.72	100.0	35.4
Percent	50.8	10.4	9.1	4.5	12.0	100.0		

Table 1-B

PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Expenditure Estimates for year ending April 30, 1942

B. Public Welfare

	Salaries	Supplies Expenses, Equipment & Renewals	Travel	Direct Financial Aid	Total	Per Cent	Cents per capita
Executive Office	$ 6,786.00*a*			$ 5,600.00*b*	$ 12,386.00	1.9	1.8
Child Welfare Division	41,419.00*c*	$6,712.00*d*	$5,763 00	460,000.00*e*	513,894.00	77.5	73.4
Welfare Supervision Board	300.00	188.00*d*	162.00	30,795.00*f*	31,445.00	4.7	4.5
Social Assistance, Unorganized Territory	6,540.00	1,345.00*d*	1,155.00	95,000.00	104,040.00	15.7	14.9
General and Unforseen		1,000.00*g*			1,000.00	0.2	0.1
TOTAL WELFARE	$55,045.00	$9,245.00	$7,080.00	$591,395 00	$662,765.00	100.0	94.7

a. Includes 10 per cent of the Deputy Minister's salary, 35 per cent of the Accountant's salary, 1 stenographers or clerks, $700.00 of the Farm Manager's salary, and $850.00 for Assistance and Relief.

b Maintenance of females in refuge homes.

c Includes a small portion of the Deputy Minister's salary, 3 supervisors, 2 inspectresses, 13 visitors, 13 stenographers, 3 clerks, and $800.00 for Assistance and Relief.

d The Welfare estimates do not separate travel from supplies, etc. The division made above is based upon the assumption that the relationship between supplies, etc., and travel would be approximately the same for Welfare as for Health. In the Health estimates, travel represented 16.2 per cent of the total for supplies, etc., and travel. Therefore, the same per cent is used in making the above divisions.

e. Mothers' Allowances and Child Care and Protection.

f Grants to Charitable Institutions.

g. This fund may be used for any unforeseen need.

Table 1-C

PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Expenditure Estimates for year ending April 30, 1942

C. Psychopathic Hospital, Mental Disease Hospitals, and Manitoba School for Mental Defectives

	Institutional					Farm					
	Salaries	Supplies, Expenses, Equipment and Renewals	Supplies	Clothing	Expenses, Equipment and Renewals	Salaries	Supplies, Expenses, Equipment & Renewals	Aid	Total	Per Cent	Cents per capita
Executive Office	$ 14,605.00[a]	$12,390.00	.....	.....	.....	$ 2,300.00	.....	$ 600.00[b]	$ 29,895.00	3.3	4.3
Psychopathic Hospital	13,006.00[c]	500.00	.....	.....	.....	.....	.....	45,500.00[d]	59,006.00	6.5	8.4
Brandon Hospital for Mental Diseases	199,530.08	.....	$120,657.92	$17,411.00	$50,806.00	11,610.00	$10,109.00	.....	410,124.00	45.0	58.6
Selkirk Hospital for Mental Diseases	125,032.00	.....	68,840.00	7,380.00[e]	28,350.00	10,410.00	6,500.00	.....	246,512.00	27.1	35.2
Manitoba School for Mentally Defective Persons. ...	83,632.50	.....	42,500.00	6,000.00	16,000.00	6,750.00	5,000.00	5,000.00[e]	164,882.50	18.1	23.6
TOTAL	$435,805.58	$12,890.00	$231,997.92	$30,791.00	$95,156.00	$31,070.00	$21,609.00	$51,100.00	$910,419.50	100.0	130.1

a Includes 20 per cent of Deputy Minister's salary, the Administrator of Estates of Mentally Incompetent and Fiscal Supervisor of Public Institutions, 2 Inspectors, 25 per cent of the Accountant's salary, 5 stenographers or clerks, approximately 77 per cent of the Farm Manager's salary, and a dentist's salary.

b. For the conservation of estates of Mentally Incompetent.

c. Includes the Provincial Psychiatrist, a Psychiatrist in charge of outpatients, an assistant Physician, an occupational therapist, a social service director, a statistician, and $150.00 for assistance and relief

d. Maintenance of patients at the Psychopathic ward of the Winnipeg General Hospital.

e Maintenance of Mental Defectives outside Institutions.

Table 1-D

PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Expenditure Estimates for year ending April 30, 1942

D. Hospitalization

	Salaries	Supplies, Expenses, Equipment & Renewals	Hospital Aid	Special Hospital Grants	Maintenance of Aged & Incurables in and outside the Province	Total	Per Cent	Cents per capita*
Administration, including Executive Office and Provincial Board of Health	$4,350.00**					$ 4,350.00	0.7	0.6
Hospitalization Division	3,182.00	$600.00				3,782.00	0.6	0.5
Statutory Aid "Hospital Aid Act"			$426,500.00			426,500.00	66.7	60.9
Winnipeg General Hospital				$13,000.00		13,000.00	2.0	1.9
Winnipeg General Nurses' Home				1,030.00		1,030.00	0.2	0.1
St. Boniface Sanatorium (Building)				1,000.00		1,000.00	0.2	0.1
Hamiota Hospital				300.00		300.00	0.03	0.03
Mount Carmel Clinic				500.00		500.00	0.07	0.07
Eriksdale Hospital				750.00		750.00	0.1	0.1
Hospital Aid in Unorganized Territory			117,000.00			117,000.00	18.2	16.8
Hospital Aid Outside Manitoba			1,000.00			1,000.00	0.2	0.1
Maintenance of Aged and Incurables					$70,000.00	70,000.00	11.0	10.0
TOTAL	$7,532.00	$600.00	$544,500.00	$16,580.00	$70,000.00	$639,212.00	100.0	91.2

* Based on estimated population of 700,000.

** Includes 5 per cent of the Deputy Minister's salary, 60 per cent of the Assistant Deputy Minister's salary, 15 per cent of the accountant's salary and 2 stenographers.

Table 1-E

PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Expenditure Estimates for year ending April 30, 1942

E. Summary

	Salaries	Supplies, Expenses, Equipment, Renewals and Clothing	Travel	Biological Products, Drugs, etc.	Farm Expenses, Salaries, Supplies, Expenses, Equipment, Renewals	Financial Aid: Regular Grants	Financial Aid: Special Grants	Total	Per Cent	Cents per capita
A. Public Health	$126,157.72	$ 25,950.00	$22,350.00	$44,000.00		$ 29,700.00		$ 248,157.72	10.0	35.4
B. Public Welfare	55,045.00	9,245.00	7,080.00			591,395.00		662,765.00	27.0	94.7
C. Psychopathic Hospital, Mental Disease, Mental Defectives	435,805.58	370,834.92			$52,679.00	51,100.00		910,419.50	37.0	130.1
D. Hospitalization	7,532.00	600.00				614,500.00	$16,580.00	639,212.00	26.0	91.2
TOTAL	$624,540.30	$406,629.92	$29,430.00	$44,000.00	$52,679.00	$1,286,695.00	$16,580.00	$2,460,554.22	100.0	351.4
Percent	25.4	16.5	1.2	1.8	2.1	52.3	0.7	100.0		

Since many of the cases requiring welfare and hospital care could have been prevented by adequate health protection and health promotion, it would seem a highly profitable investment to spend a little more on public health and mental hygiene as an assured means of eventually reducing the need both for mental and general hospital care and for welfare services.

In analysing the estimated expenditures for public health (Table 1-A), it is obvious that a very small amount is spent for assisting local full-time health units—only 7.4 per cent of the total, or 2.6 cents per capital. The actual amounts, and the proportion of total expenditures, spent for Maternal and Child Health are ridiculously low—1.0 per cent or three-tenths of one cent per capita. Expenditures for general administrative services, as indicated by the executive office, are unusually low—3.1 per cent of the total and 1.1 cents per capita—due principally to the low salaries paid. The amounts spent for acute communicable disease and venereal disease control would be low except for the rather substantial sums spent for biologic products which in many other areas are either manufactured by the Department or supplied through federal assistance.

Manitoba spends for public health through its Department of Health a total of 35.4 cents per capita, based on an estimated population of 700,000, of which 31.8 cents goes to the Central Office and only 3.6 cents for aid to local health service, including one cent per capita for salaries of part-time health officers in unorganized territory. This means that only ten per cent of the provincial expenditures for public health is allocated to full-time local health departments.

This imbalance between Central Office expenditures and aid to local health service becomes even more apparent if the expenditures for the tuberculosis traveling clinics and for cancer control are included. Adding to the $248,157.72 spent by the Provincial Health Department, an estimated $19,000.00 for the tuberculosis traveling clinics and $17,500.00 for cancer control (exclusive of the $4,500.00 provincial grant to the Cancer Relief and Research Institute which has already been included), gives a total of $284,-657.72, or 40.7 cents per capita. Since these services are province-wide rather than local, this means that direct financial aid to local health services, $25,200.00, amounts to slightly less than 8.9 per cent of the total.

Table 2 gives a brief comparative analysis of public health expenditures in Manitoba, Florida, Michigan and Oklahoma. In considering the figures of this table, one should bear in mind the following points:

(*a*) In each instance, figures for the Central Office and for local full-time health units are exclusive of cities having full time health units. Thus, in Manitoba figures are based on a population of 465,539 which excludes the populations and public health expenditures of the cities of Winnipeg and Brandon. In Florida, the populations and health expenditures of Jacksonville, Miami and Tampa have been excluded; in Michigan, the populations and expenditures of eleven cities having full-time health departments, and in Oklahoma the population and expenditures of Oklahoma City are omitted. These omissions have been made on the premise that as far as financial aid is concerned, the major responsibility of provincial and state health departments is to rural areas rather than to cities.

(*b*) The expenditures are for different years,—in Manitoba for the current fiscal year ending April 30, 1942, in Florida for the year 1939, in Michigan for 1938, and in Oklahoma for 1937.

(c) Expenditures for local health service include both Provincial (or State) financial aid and local appropriations.

(*d*) Expenditures for the Central Office include only expenditures made through the Provincial (or State) health departments. They do not include expenditures of voluntary or quasi-official agencies.

Table 2

OFFICIAL PUBLIC HEALTH EXPENDITURES IN MANITOBA, FLORIDA, MICHIGAN AND OKLAHOMA

Purpose	Manitoba[1]	Florida[2]	Michigan[3]	Oklahoma[4]	Cents per capita				Per Cent of Total			
					Man.	Fla.	Mich.	Okla	Man.	Fla	Mich.	Okla.
Central Office	$222,958.00[a]	$351,570.00	$ 640,369.00	$451,637.00[b]	47.9	26.9	23.9	19.4	89.8	55.7	44.9	72.8
Full-time Local Health Units *	25,250.00	279,774.00	786,406.00	168,561.00	5.4	21.4	29.3	7.2	10.2	44.3	55.1	27.2
TOTAL	$248,208.00	$631,344.00	$1,426,775.00	$620,198.00	53.3	48.3	53.2	26.6	100.0	100.0	100.0	100.0
Training		$ 10,000.00	$ 55,067.00	$ 62,500.00		0.8	2.1	2.7				
Aid to Cities	$ 11,920.00[c]		44,450.00		2.6		1.6					
Part-time Health Officers	7,000.00				1.5							
Malaria, Hookworm, etc.		50,800.00				3.9						
Total	$ 18,920.00	$ 60,800.00	$ 99,517.00	$ 62,500.00	4.1	4.7	3.7	2.7				
GRAND TOTAL	$267,128.00	$692,144.00	$1,526,292.00	$682,698.00	57.4	53.0	56.9	29.3				

NOTE: Figures do not include either populations or expenditures of cities having full-time health departments.

* Includes local, state or provincial and philanthropic agency funds

[1] Population 465,539; Budget for 1941-1942.

[2] Population 1,305,950; Budget for 1938-1939.

[3] Population 2,680,684; Budget for 1937-1938.

[4] Population 2,328,000; Budget for 1936-1937.

a. Includes estimated $50,700.00 for nursing services in areas without full-time health units.

b. Includes estimated $70,200.00 to areas without full-time health service.

c. Brandon Health Unit.

These figures clearly indicate the need for more financial aid to full-time local health departments.

While Manitoba's public health expenditures through the Provincial Department for 1942 are as high as those of the Michigan State Department of Health in 1937-1938, and higher than those of Florida in 1938-1939 and Oklahoma in 1936-1937, the difference in dates should be borne in mind. Unfortunately, more recent figures are not immediately available in sufficient detail for useful comparisons. However, it is known that both Florida and Oklahoma have had substantial increases in their appropriations, and that Michigan has had modest increases since these data were obtained. This table compares Manitoba with one reasonably well-to-do state and two states which are considered poor. It must also be remembered that Manitoba's population is very much less than the states with which it is compared, and that the smaller the unit of population, the greater the per capita cost of rendering any given service. In the light of these observations, Manitoba's general public health expenditures are not notably low.

On the other hand, the provincial expenditure for local health service is extraordinarily small. Even when Florida and Oklahoma were giving least support to local health service, they still spent on it considerably more, both actually and in proportion, than Manitoba does now. Manitoba allots but 5.4 cents per capita on full-time rural health units as compared with 7.2 cents in Oklahoma, 21.4 cents in Florida and 29.3 cents in Michigan. (Both Oklahoma and Florida spend considerably more now.) Only 10.2 per cent of Manitoba's health expenditure for the Central Office and full-time health units is devoted to local health service, as compared with 27.2 per cent in Oklahoma, 44.3 per cent in Florida and 55.1 per cent in Michigan.

One other striking fact brought out in this table is that Manitoba has no appropriation for the training of public health personnel.

As a means of correcting these two very apparent deficiencies in public health expenditures, it is recommended:

1. THAT LARGER APPROPRIATIONS BE MADE FOR THE SUPPORT AND DEVELOPMENT OF FULL-TIME LOCAL HEALTH DEPARTMENTS.

2. THAT A SPECIAL APPROPRIATION BE MADE FOR TRAINING PUBLIC HEALTH PERSONNEL.

   This fund should be used not only for training new personnel but also for providing additional training for persons who have already had some but need more. While the Rockefeller Foundation has been very generous in providing fellowships for medical

public health personnel, it can hardly be expected to furnish such training indefinitely.

3. THAT AN EFFORT BE MADE TO OBTAIN FEDERAL AID IN ADDITION TO PROVINCIAL APPROPRIATIONS FOR DEVELOPING FULL-TIME LOCAL HEALTH DEPARTMENTS AND FOR TRAINING PUBLIC HEALTH PERSONNEL.

Personnel. Public health has advanced far since the time when the quarantine of communicable diseases and police power were considered the main functions of a Health Department. Today the programs embraced by a Health Department are so varied and extensive that public health must be considered as including many specialties.

If public health personnel is to provide beneficial service, it must be trained in the principles, policies, techniques and methods of modern public health. An incompetent physician endangers the lives of his patients, but an incompetent health official may endanger the lives of the people in an entire state or province.

The director of a bureau or division in the health department must have knowledge of the broad field of public health and a particular grasp of the specialties included in his own administrative branch. All technical personnel engaged in the various phases of a health program must be trained to fulfill the duties expected of them. In addition to specific practical training and experience, a general knowledge of the background of public health and its specialties is an essential qualification.

One of the important functions of any provincial or state department of health is to provide its personnel with opportunity for advanced training and supplementary facilities for practical experience in public health. This is not only of value to the individual but brings the health service multiple benefits in return for the energy and money expended.

It has been found that certain policies stimulate personnel to take enthusiastic interest in the program and result in the best possible service to the people, such as:

(*a*) Security in tenure of office to eliminate the fear of unwarranted removal;

(*b*) Salaries commensurable with duties and responsibilities;

(*c*) Opportunities for promotion with periodic increases in salaries on a merit basis;

(*d*) A definite understanding of the duties of the individual and an exact drawing of lines of responsibility so that each will know what is expected of him and to whom he is accountable.

Only when each individual faithfully and capably fulfills his duties will the organization function as a smooth-running machine. These principles apply to every person employed in the health service from the janitor and office boy to the administrative heads and executive officers.

Every employee should have an intelligent grasp of the principles and policies of the health department and a general idea of the various services it supplies. In the daily contacts of each individual, especially those required to meet the public or answer the telephone, many enquiries are made concerning the health department. If the personnel can not answer questions or give information, the department suffers. Staff meetings, service manuals and house organs (information bulletins), can present and summarize activities to the personnel. Suggestions for the improvement of services should be requested and encouraged from all employees and credit given for constructive ideas.

If the best and keenest young physicians, nurses, engineers, laboratory technicians, and so on, are encouraged to enter the public health service, provincial and local public health will advance to a high plane in pursuit of its objective, which is to assist people to live healthier, happier and fuller lives. Public health, as a career service with security, adequate salaries, promotion, responsibility, enthusiasm and honesty of purpose, guided by scientific knowledge, may accomplish this end.

Tables 3-A and 3-B analyse the personnel in the Manitoba Department of Health and Public Welfare. As previously stated, the persons in key positions are well trained and capable. However, with few exceptions, there are no competent assistants. This is brought out clearly by the table where it will be noted that in certain divisions there is but one professionally trained person. The need for more professionally trained personnel is obvious. Altogether there are but eleven physicians in the entire Department, exclusive of the Hospitals for Mental Diseases and the Manitoba School for Mentally Defective Persons, seven in general administration and public health, three in the psychopathic hospital and one in hospitalization. The Department has no public health engineers and no statisticians although there is a statistical clerk in the Division of Psychiatry. Of the total of 143 persons in the Department, 43, or 30 per cent, are stenographers or clerks. This would seem to be an unusually high proportion of clerical help but is accounted for, in part, by the fact that all persons working in the Division of Vital Statistics, except the director, are listed as stenographers or clerks.

Table 3-A

PERSONNEL IN THE MANITOBA DEPARTMENT OF HEALTH AND PUBLIC WELFARE*

August, 1941

PUBLIC HEALTH	Chief Administrative Officer	Directors of Divisions	Asst. Directors of Divisions	Physicians other than Executives	P.H. Nursing Supervisors	Field Public Health Nurses	Social Work Supervisors	Social Work Visitors	Inspectors and Inspectresses	Bacteriologists	Laboratory Technicians	Public Health Engineers	Statisticians	Stenographers and Clerks	Others	Total	Per Cent of Public Health	Per Cent of Grand Total
General Admin.	2a																	
Comm. Disease (except V.D.)		1												4	2b	2	2.2	6.3
Venereal Disease		1												1		2	2.2	1.4
Maternal and Child Health		¼												1		2	2.2	1.4
Public Health Nursing		1	1		5	32								½		¾	0.8	0.5
General Sanitation		1												2		41	45.1	28.7
Food and Milk Control		1½							2c					½		4½	4.9	3.1
Health Education		¾							2c					½		4½	4.9	3.1
Laboratory		1d												½	4½	5¼	5.8	3.7
Vital Statistics		1h								1	8				1	11	12.1	7.7
TOTAL PUBLIC HEALTH	3	8	1	0	5	32	0	0	6	1	8	0	0	20	7	21	100.0	62.6

(See footnotes next page.)

Table 3-B

PERSONNEL IN THE MANITOBA DEPARTMENT OF HEALTH AND PUBLIC WELFARE* (Cont'd)

August, 1941

PUBLIC WELFARE	Chief Administrative Officers	Directors of Divisions	Asst. Directors of Divisions	Physicians other than Executive	P.H. Nursing Supervisors	Field Public Health Nurses	Social Work Supervisors	Social Work Visitors	Inspectors and Inspectresses	Bacteriologists	Laboratory Technicians	Public Health Engineers	Statisticians	Stenographers and Clerks	Others	Total	Per Cent of Public Welfare	Per Cent of Grand Total
Child Welfare	...	1	...	...	...	...	3	13	2	...	...	...	...	16	...	35	83.3	24.5
Social Assistance, Unorganized Terr.	...	1	...	...	...	...	...	...	1	...	...	...	...	4	...	6	14.3	4.2
Grants to Charitable Institutions	...	[a]	...	...	...	...	...	...	...	...	...	...	...	...	...	1	2.4	0.7
TOTAL PUBLIC WELFARE	0	2	0	0	0	0	3	13	3	0	0	0	0	20	0	42	100.0	29.4
Psychopathic Hospital	...	1	...	2	...	...	...	...	...	...	...	...	1	...	2	6	...	4.2
Hospitalization	...	...	1	...	...	...	...	...	...	...	...	...	...	3	...	4	...	2.8
GRAND TOTAL (Health, Welfare and Hospital)	3	12	2	2	5	32	3	13	9	1	8	0	1	43	3	142	...	100.0

* Exclusive of personnel in the Hospitals for Mental Diseases, the Manitoba School for Mentally Defective Persons, and staff required in connection with estates of the mentally incompetent and supervision of public institutions.

a. Includes the Minister, Deputy Minister and Assistant Deputy Minister. (Two are physicians).
b. Accountant and Farm Manager.
c. One has recently joined the Army.
d. A Veterinarian.
e. One sanitary inspector, one milk inspector, and a milk technician.
f. Librarian and 3 assistants in Health Education.
g. He is the Provincial Bacteriologist.
h. Has recently joined the Army.
i. Part-time Secretary of Welfare Supervision Board.
j. Occupational therapist and Social Service Director.

SECTION OF ADMINISTRATION

The Section of Administration, as recommended in the Organization Chart on page 26A, includes the Bureaus of General Administration, Statistics and Records, Laboratories, and Health and Welfare Education.

GENERAL ADMINISTRATION

General Administration in the Department of Health and Public Welfare is somewhat loosely organized. No one person is charged with responsibility for the various services comprised in general administration, such as management, finance, personnel supervision, supplies, and telephone, mail, and janitor service. The business aspects of an organization, such as the Provincial Department of Health and Public Welfare, are of fundamental importance.

It is therefore recommended:

THAT A BUREAU OF GENERAL ADMINISTRATION BE ESTABLISHED, UNDER THE DIRECTION OF A BUSINESS MANAGER AND PERSONNEL DIRECTOR WHO SHOULD BE RESPONSIBLE TO THE DEPUTY MINISTER OF HEALTH AND PUBLC WELFARE.

STATISTICS AND RECORDS

The Division of Vital Statistics as organized at present is in charge of a physician who lacks special training but has real interest and ability in making statistical studies. There is one person in the Division with some experience in statistical methods. Unfortunately, the director has been lost to the Department through assignment to active military duty.

The staff consists of a director and ten stenographer-clerks. Estimated expenditure is $18,306.00 of which $12,906.00 is for salaries and $5,400.00 for supplies, equipment, et cetera.

The most noteworthy achievements of the Division are some recent studies of neonatal deaths and prenatal care made in cooperation with committees of the Manitoba Division of the Canadian Medical Association. The routine work of the Division has increased greatly during the past year because of an unusual demand for copies of birth certificates.

Numbers and rates for total deaths and specific causes, and for births and birth rates, are compiled and published currently. It is only during the past four years, however, that births and deaths have been properly allocated to place of residence.

The weakness of the work in the Division of Vital Statistics is that figures and rates have not been broken down by districts except for one or two special studies. Statistics on tuberculosis have been tabulated and analysed for seven districts, but this work was done through the Central Tuberculosis Registry. The Division does not keep morbidity figures nor does it have anything to do with service or activity records of the Department as a whole.

Unfortunately the Division is housed in the Legislative Building which is quite a distance from the building which houses the other divisions of the Department of Health and Public Welfare except for General Administration which is also in the Legislative Building.

In order that the work of the Division of Vital Statistics may be more effectual, it is recommended:

1. THAT AN ASSISTANT TO THE DIRECTOR OF THE DIVISION OF VITAL STATISTICS BE APPOINTED TO TAKE CHARGE OF THE DIVISON DURING THE ABSENCE OF THE DIRECTOR. THE PERSON CHOSEN FOR THE POSITION SHOULD BE WELL-TRAINED AND EXPERIENCED IN STATISTICAL METHODS AND PREFERABLY IN PUBLIC HEALTH METHODS AS WELL.

   The acting director should be a young person capable of eventually succeeding the director.

2. THAT AS SOON AS POSSIBLE THE DIVISION OF VITAL STATISTICS, AS WELL AS THAT OF GENERAL ADMINISTRATION, BE MOVED TO THE GROUNDS OF 320 SHERBROOK STREET.

   In order to do this it will be necessary to construct an additional building because there is not sufficient space in the present Health and Welfare quarters. When the new building, which should contain fireproof vaults for the storage of vital records, is erected, it would seem wise to include sufficient space also to house the laboratories and to provide a small separate building for laboratory animals.

3-*a*. THAT THE DIVISION CHANGE ITS NAME FROM THE DIVISION OF VITAL STATISTICS TO THE BUREAU OF STATISTICS AND RECORDS, AND THAT IT BECOME A BUREAU OF THE SECTION OF ADMINISTRATION.

(See Organization Chart, page 26A.)

b. THAT THE FUNCTIONS OF THE BUREAU OF STATISTICS AND RECORDS BE BROADENED TO INCLUDE THE COMPILATION, TABULATION, AND ANALYSIS OF ALL STATISTICS AND RECORDS OF

THE ENTIRE DEPARTMENT, INCLUDING NOT ONLY VITAL STATISTICS (BIRTHS, DEATHS, MARRIAGES, ETC.) BUT ALSO MORBIDITY RECORDS AND SERVICE RECORDS OF ALL BUREAUS AND DIVISIONS.

In order to perform these functions satisfactorily, it is obviously essential that the Bureau be sufficiently staffed to enable it to tabulate and analyse currently service records obtained from the several bureaus and divisions of the Department and to return this information promptly to the bureaus and divisions from which they originated. Information relative to local health department areas should be made currently available to such departments.

4. THAT NO RECORD FORMS IN ANY BUREAU OR DIVISION OF THE DEPARTMENT BE PRINTED OR USED UNTIL THEY HAVE BEEN REVIEWED AND APPROVED BY THE DIRECTOR OF THE BUREAU OF STATISTICS AND RECORDS.

The individual bureau or division director will naturally indicate what information he needs. The Director of the Bureau of Statistics and Records can assist in the arrangement of the record forms so as to facilitate tabulation and analysis, and it should be his prerogative to question the usefulness of each item which is proposed as part of the form. Field records to be used by local health departments should likewise be approved by the Director of the Bureau of Statistics and Records.

5. THAT, SINCE THE RECORDS OF THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE ARE NOT NOW UNIFORM, AND IN SOME INSTANCES NOT SATISFACTORY, THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE REQUEST ASSISTANCE FROM THE COMMITTEE ON RECORDS OF THE STATE AND PROVINCIAL HEALTH AUTHORITIES IN DEVELOPING AND STANDARDIZING ITS RECORD SYSTEM.

LABORATORIES

The Laboratory of the Provincial Department of Health and Public Welfare is housed in the Medical School of the University of Manitoba adjoining the Winnipeg General Hospital. It is used for teaching purposes by the Medical School.

The Division of Laboratories is directed by the Provincial Bacteriologist who is a well qualified physician with special training and wide experience in bacteriology. In addition, the staff consists of an assistant bacteriologist, eight technicians and one cleaner, making a total of eleven. Estimated expenditure totals

$19,420.72 of which $16,320.72 is for salaries and $3,100.00 for supplies, equipment, et cetera.

The Provincial Bacteriologist also teaches at the Medical School and is doing some very interesting research in septicemia and arthritis.

The Laboratory carries on the usual public health procedures, but does not, like some of the larger organizations, manufacture biologics. As might be expected from the meagre funds appropriated for its conduct, the laboratory is small. It serves the entire province, and while it has no recognized branches, the laboratory at the Brandon Hospital for Mental Diseases actually functions as one, since it provides most of the public health laboratory services for the western part of the Province. If the Brandon laboratory is to continue to function as at present, and it seems certain that it will, then it should be recognized as a branch laboratory, come under the supervision of the central laboratory, and receive periodic supervisory field visits.

While the work of the Provincial Laboratory seems to be done well, it suffers from the disadvantages of being a one-man organization. This is, in fact, almost literally true, since all but one of the technical assistants are women. The assistant bacteriologist is well-trained and capable, but nevertheless it would seem desirable to have a man as assistant director in view of the unusually difficult decisions which must often be made in laboratory administration.

Although there are comparatively few laboratories in Manitoba, there are as yet no minimum requirements for their establishment and conduct. Meanwhile, as additions are made to the full-time health departments, and the number of municipal doctors increases, there will be a marked growth in the demand for laboratory services, and therefore a need for additional laboratory personnel.

In conformity with the foregoing discussion, it is therefore recommended:

1. THAT AT THE EARLIEST POSSIBLE MOMENT A YOUNG MAN, WELL-TRAINED AND EXPERIENCED IN PUBLIC HEALTH LABORATORY PROCEDURES, BE APPOINTED AS ASSISTANT DIRECTOR OF LABORATORIES.

2. THAT THE LABORATORY AT THE BRANDON HOSPITAL FOR MENTAL DISEASES BE MADE THE WESTERN BRANCH OF THE PROVINCIAL LABORATORIES, AND THAT IT RECEIVE PERIODIC SUPERVISORY VISITS FROM THE CENTRAL LABORATORY.

3. THAT THE MINISTER OF HEALTH AND PUBLIC WELFARE GIVE CONSIDERATION TO THE DEVELOPMENT OF MINIMUM REQUIREMENTS FOR THE ESTABLISHMENT AND CONDUCT OF LABORATORIES.

HEALTH AND WELFARE EDUCATION

The health education activities of the Provincial Department of Health and Public Welfare were organized into a division in 1939. A director was appointed who is a doctor of medicine with a diploma in public health. She is also a director of the Division of Maternal and Child Hygiene and medical officer in relation to Part III of the Child Welfare Act. It is estimated that approximately three-fourths of her time is devoted to health education.

In addition to the director and three assistants, the staff consists of a librarian and a half-time clerk. A public health nurse attached to the Division of Public Health Nursing gives courses in health education in the two normal schools and to the education students of the University of Manitoba. Other nurses are loaned by the Division of Public Health Nursing to give courses in public health education when needed.

The present budget for the Division is $9,495.75. Of this amount, $7,095.75 is for salaries, and $2,400.00 for travel, supplies and equipment. The salary item includes 75 per cent of the director's salary.

In the early history of the development of public health administration little thought was given to health education as a specialty. It was usually a by-product of personal service on the part of doctors, nurses, engineers or other persons. That was the age of doing things for people rather than instructing them in how to take part in the solution of their own problems. Following this period, health education went through a barn-storming era. Health information was widely disseminated by many agencies and individuals without purposeful planning and usually without evaluation of results. This period is only now coming to a close. Administrators have learned at last that education can and should be planned like the other parts of the health program to meet the needs of the individual and the community.

Education is the spearhead behind which the entire health program must advance. Therefore, the first objective of a department of health and public welfare should be a plan by which information concerning health and welfare will be interpreted to each

individual in the area at the level of his intelligence, interest and needs.

The majority of the people in this province, as in many other parts of the country, are unaware of the advantages of a well-planned public health program to the individual and to the community. For example, they do not realize that many maternal deaths and much ill-health could be avoided by proper supervision during the prenatal and postpartum periods, and infant mortality lowered by the practical application of known preventive measures. They are ignorant of the fact that many children in the province have physical defects which, if not corrected, may lower their efficiency and in many cases result in crippling conditions and dependency in later life; that such diseases as tuberculosis and syphilis can be eradicated by accepted measures of control. They have not learned that the health and physical efficiency of a large percentage of our population could be improved by a better understanding of nutrition, that at least some mental illness is preventable, and that education which opens the way to these ameliorations is a sound financial investment.

It has been demonstrated in many communities that when these facts have been made known, the people have demanded and been willing to pay for the protection afforded by adequate health services. The first major objective of this Department of Health and Public Welfare should therefore be to present this information to the citizens of the province. It will be necessary in so doing to use all the teaching methods known to pedagogues, and all available channels and techniques of publicity, such as the personal medium, the press, the radio, printed matter, the cinema, lantern slides, and exhibits.

Resources for Health Education. There are many potential resources for health education in this province. Numerous agencies are already doing excellent work in the field. Maximum results can be obtained, and duplication and gaps in service prevented only when all resources are utilized, and the activities of individuals, groups, agencies and departments co-ordinated into a province-wide program. At present there is very little planning on this universal basis. Among the official and non-official agencies which should participate in the program are:

The Dominion Government.
The Department of Health and Public Welfare.
The Department of Education.
The Department of Agriculture.
The Department of Labour.
The Manitoba Sanatorium Board.
The Dominion Provincial Youth Training Program.
The Manitoba Division of the Canadian Medical Association.
The Manitoba Dental Association.
The Manitoba Federation of Agriculture.

The Manitoba Hospital Association.
The Manitoba Division of the Canadian Adult Education Association.
The Canadian Foundation for Preventive Dentistry.
The Manitoba Teachers' Federation.
The Manitoba Association of Registered Nurses.
The Imperial Order of Daughters of the Empire.
The Women's Institute (Department of Agriculture).
The Parent-Teacher Associations.
The Victorian Order of Nurses of Canada.
Schools of Higher Learning.
The Cancer Relief and Research Institute.
The School Trustees.
The Union of Municipalities.
The Red Cross Society.
St. John Ambulance Association.
The Council of Social Agencies of Greater Winnipeg.
The Attorney-General's Department.
Children's Aid Societies.
The Press.
The Clergy.

Provincial Health and Welfare Education Council. The development of interest in health and welfare and the co-ordination of activities of the foregoing and other agencies including strictly lay groups are basic to any sound health education program. This objective can probably best be obtained through the formation of a Provincial Health and Welfare Education Council.

Press Releases. The press is an important medium through which to keep the public informed concerning local health problems, available curative and preventive services, and discoveries in medicine and related sciences. The Department of Health and Public Welfare has not at the present time a detailed local or province-wide press-release plan. Press notices are released through the office of the Deputy Minister of Health when indicated.

Department Publications. The Department of Health and Public Welfare is one of the major departments of the Provincial Government. Its activities should be of interest to every individual in the province. To maintain this interest and to help in securing adequate financial support, its activities and needs should be kept constantly before the public. To this end a monthly Health and Welfare Bulletin should be published with a mailing list including, among others, departments of government, official and non-official agencies and key individuals. Articles and news items should be prepared by the staff. The bulletin should be edited by the staff of the Bureau of Health and Welfare Education. The librarian now edits a monthly Library News Bulletin which lists new additions to the library and is mailed to approximately one hundred health and welfare officials. All department publications, press notices, radio talks, educational pamphlets, scientific papers and other material prepared for general distribution by staff members should be presented to the Bureau for critical evaluation and be approved by the Deputy Minister before release.

Mechanical Media. The value of mechanical media such as the motion picture, the radio, the exhibit and printed matter is recognized in the field of health education. Mechanical media supplement the personal medium in teaching, lecturing and consultation. They are less expensive than the personal medium and well suited to arouse interest of the masses and make them more receptive to the personal medium.

The possibilities of the use of mechanical media, in interpreting the factors bearing on health and welfare so that people will be influenced in the direction of healthier and happier living, have scarcely been touched. There is a wide and varied range of subject material which in fact includes the entire field of health, welfare and medicine. The preparation of such material requires a source of authentic information and a staff with imagination and artistic and technical ability.

The Director of the Division of Health Education understands the importance of mechanical media in health education and within budgetary limitations this part of the program is well developed. The radio program includes a weekly broadcast prepared and given by Department staff members. Health pamphlets from several reliable sources are discriminately distributed. The Department owns sound motion picture equipment which is available with operator to groups in the province. The film library includes only two films, but the Department of Education has fifty health films available. Exhibit material of good quality but limited quantity is prepared by the staff of the Division.

Staff Education and Meetings. The Provincial Department of Health and Public Welfare does not have regular staff meetings. Such meetings are highly desirable from the standpoint both of the individual and of the Department as a whole.

The staff of the Department consists of persons professionally and technically trained as well as the clerical assistants. It is essential for each staff member to realize that while he may act independently in performing a highly specialized service, he must also function as one of a team. Thus, each staff member should have a working knowledge of the organization, functions and general administrative policies of each branch, bureau and division of the Department, and of its inter-relations with other departments of government.

Each person must keep in mind that he not only represents his own specialty but also the entire Department. Thus, in the field, a staff member should be sufficiently informed concerning all aspects of the program to act as a general consultant, and to refer correctly problems requiring highly technical advice.

Regular staff meetings present an opportunity for the Deputy Minister of Health and Public Welfare to keep the entire staff informed concerning administration changes, current problems and other matters of interest to the entire Department. They also permit a director and his staff to discuss with the Deputy Minister and other staff members, the policies, functions, inter-relationships and needs of his bureau or division. In addition to the general staff meetings, section staff meetings will be found of value.

In-service training programs should be developed according to the internal necessities of the various bureaus. The staff of the Division of Health Education should take an active part in planning such in-service training programs.

Health and Welfare Regional Meetings. The success of the health and welfare program will not be great if it relies entirely upon the efforts of its own staff. To attain the maximum in health and welfare there should be province-wide co-ordination of the efforts of all departments, agencies and persons working in the field, such as health officers, municipal doctors, private physicians, hospital staffs, nurses, social workers, nutritionists, sanitarians, dentists, and others. To accomplish such co-ordination there should be regional meetings for definition of health and welfare problems, evaluation of health and welfare resources, and long range health and welfare planning. Such meetings should be educational. They will give the Deputy Minister of Health and Public Welfare and his staff an opportunity to present new administrative policies, proposed legislation and other issues of broad interest to the assembled groups. The Director of the proposed Bureau of Health and Welfare Education in co-operation with the Deputy Minister and staff should plan such meetings.

Field Consultation Service. One of the most important functions of the Bureau of Health and Welfare Education (hereafter to be recommended) should be to furnish expert consultation service to local communities. This should be given first in areas having full-time health service. Local health officers usually have had but limited training, and their staff little or none, in community organization and teaching methods and techniques. They logically look to the Provincial Department for help in this field. Through the Bureau of Health and Welfare Education a specialist should be available to assist local health officers in planning staff education and community programs. Every service given by a member of the health department should be a teaching experience for the staff member and an educational experience for the person receiving the service. The health education consultant should assist the local health officer in evaluating the personal approach of physicians, nurses, sanitarians, and others, to discover whether the public is obtaining the maximum educational benefit from their ministrations.

The education specialist should be qualified to give expert advice to local health personnel on community planning for health education. There are many potential resources for health education in every community in the Province. It is the responsibility of the health officer to assume leadership in mobilizing these resources into a co-ordinated program. Such programs should be developed to meet individual and community needs. While fully utilizing the consultation service, community programs should be developed locally, since the primary objective of such programs is to teach individuals to recognize and participate in solving their own health problems. In other words, as a well known health educator has said, "Doing things for people is often easy, but it is often expensive and of temporary benefit. Showing people how to do things for themselves may take a little more time but it is relatively inexpensive and its results are lasting."

From this review of proposed activities, it is apparent that the full-time services of a person suited by personality, experience and training, is needed to direct the program. The present Director of the Division gives only part time to the work.

The Director of the Division co-operates in planning a course in health education for the two normal schools. The course is compulsory and is conducted for forty-five minutes daily for five days each week during the school year. She also co-operates in planning a health education course for education students of the University of Manitoba which occupies one hour weekly for two terms. A nurse from the Division of Public Health Nursing, without training in pedagogy, gives the course. It is strongly urged that the subject of health education be retained in the curriculum of the schools of higher learning, and that the staff of the Provincial Department of Health and Public Welfare be available for consultation to such institutions. The courses should be taught, however, by suitably trained members of the faculties.

The Director of the Division of Health Education gives physical examinations to all students taking these courses. She spent approximately twenty-five per cent of her time during the past year in giving physical examinations to students and other groups. While physical examination of students in such institutions is desirable, this should not be the function of physicians on the staff of the Provincial Department of Health and Public Welfare.

A specialist in health education should be added to the staff, as assistant to the director. The candidate should be qualified by personality, experience and educational background, to assume, if necessary, the duties of director, and be skilled in teaching techniques, in English composition and public speaking, in group work and community organization.

In order to implement the program outlined in the preceding pages, it is recommended:

1. THAT THE ACTIVITIES OF THE DIVISION OF HEALTH EDUCATION BE REORGANIZED TO CONFORM TO SUGGESTIONS MADE IN THIS DISCUSSION AND THAT THE DIVISION HENCEFORTH BE KNOWN AS THE BUREAU OF HEALTH AND WELFARE EDUCATION.

2. THAT THE ACTIVITIES OF THIS BUREAU BE DIRECTED BY A PROPERLY QUALIFIED PERSON WHO WILL DEVOTE HIS OR HER ENTIRE TIME TO THE POSITION.

3. THAT A HEALTH EDUCATION SPECIALIST BE ADDED TO THE STAFF OF THE BUREAU OF HEALTH AND WELFARE EDUCATION TO ACT AS ASSISTANT TO THE DIRECTOR.

4. THAT THE MAJOR EMPHASIS OF THE HEALTH EDUCATION PROGRAM BE PLACED UPON HELPING COMMUNITIES, THROUGH INDIVIDUAL AND GROUP EFFORT, TO DEFINE THEIR OWN HEALTH PROBLEMS AND TO TAKE AN ACTIVE PART IN THEIR SOLUTION.

5. THAT THE SERVICES OF A HEALTH EDUCATION CONSULTANT, TRAINED IN TEACHING METHODS AND COMMUNITY ORGANIZATION, BE MADE AVAILABLE THROUGH THE SECTION OF LOCAL HEALTH SERVICES TO LOCAL COMMUNITIES ON A CONSULTATION BASIS.

6. THAT THE DEPUTY MINISTER OF HEALTH AND PUBLIC WELFARE APPOINT A COMMITTEE OF FIVE MEMBERS, THREE FROM OFFICIAL AND TWO FROM NON-OFFICIAL AGENCIES, TO FORM A MANITOBA HEALTH AND WELARE EDUCATION COUNCIL, AND THAT THIS COMMITTEE CEASE TO FUNCTION AFTER THE COUNCIL IS ORGANIZED.

7. THAT REGIONAL MEETINGS FOR PERSONS PROFESSIONALLY ENGAGED IN THE FIELD OF HEALTH AND PUBLIC WELFARE AND OTHER INTERESTED PERSONS BE HELD AT INTERVALS AND IN PLACES TO BE DECIDED BY THE DEPUTY MINISTER OF HEALTH AND PUBLIC WELFARE.

8. THAT DEPARTMENT STAFF MEETINGS BE HELD AT REGULAR INTERVALS.

9. THAT A PLAN FOR PRESS NEWS RELEASES AT INTERVALS AND AT SPECIAL TIMES AS INDICATED BE FORMULATED AND EXECUTED ON A PROVINCE-WIDE BASIS.

10. THAT A MONTHLY HEALTH BULLETIN BE PUBLISHED AND THAT THE MONTHLY LIBRARY NEWS BULLETIN BE DISCONTINUED AS A SEPARATE PUBLICATION AND LIBRARY NEWS ITEMS BE INCLUDED AS A SECTION IN THE MONTHLY HEALTH BULLETIN.

11. THAT THE BUDGET FOR MECHANICAL MEDIA FOR HEALTH EDUCATION BE INCREASED.

SECTION OF PREVENTIVE MEDICAL SERVICES

The section of preventive medical services includes the Bureaus of Disease Control, Maternal and Child Health and Public Health Nursing.

DISEASE CONTROL

Too many services are included in the present Division of Disease Prevention and the grouping is not logical. It should be reorganized to include, so far as possible, services functionally related. The Present Division includes:

Hospitalization.
Private Hospitals.
Care of the Aged and Infirm.
Communicable Disease Control.
Venereal Disease Control.
Public Health Nursing including Central Tuberculosis Registry, and Dental Clinics.
Industrial Hygiene.
Food Control.
Sanitation.

The Bureau of Disease Control (as hereafter recommended) should be directed by a physician suited by personality, training and experience for such work. His background should include, among other things, detailed information on the legal aspects of disease control. He must understand the importance of keeping records and of analysing and using data from records as means of defining problems, evaluating services and planning programs. As an expert in disease prevention, it should be his responsibility, with the aid of his staff and the Bureau of Health Education, to keep the medical profession advised concerning progress in this field, and his participation in the health education program should help inform the people regarding measures in which their cooperation is required.

The Bureau of Disease Control through its divisions should function primarily in an advisory-supervisory capacity. The ideal is to give direct service only in highly specialized fields—in other fields on a demonstration basis only, and in time of emergency. Practically speaking, however, this ideal can not be achieved for the present and it is necessary to give certain direct services, especially in unorganized territory. Direct services should usually be given by local health officials, and the most productive outlet for the activities of the Bureau of Disease Control is to help the staffs of full-time health units to develop their own local disease-control programs.

The staff of the Division of Communicable Disease Control, exclusive of Venereal Disease, consists of a physician, who is the Director, and one clerk. The total budget for the year ending April 30, 1942, is $37,104.50, of which $4,604.50 is for salaries, $8,700.00 for office supplies and equipment, $800.00 for travel, and $23,000.00 for biologics and drugs.

The following table presents certain communicable diseases including tuberculosis, syphilis and gonorrhea, reported in Manitoba for the past ten years.

REPORTED CASES OF CERTAIN COMMUNICABLE DISEASES

Manitoba, 1921-1910*

Disease	1921	1922	1923	1924	1925	1926	1927	1928	1929	1910
Anterior Poliomyelitis	15	7	8	10	22	339	261	159	24	17
Chicken Pox	1,721	1,379	2,062	1,971	2,214	1,522	1,816	2,582	1,[illegible]	2,112
Diphtheria	526	401	405	472	276	171	165	234	282	211
Erysipelas	121	75	62	22	91	122	91	87	92	82
Influenza	84	20	527	119	225	290	18,571	107	252	207
Measles	4,068	1,741	104	10,888	5,176	7,322	2,829	743	1,072	12,144
Mumps	2,399	686	741	275	2,621	1,202	252	2,419	1,995	694
Scarlet Fever	1,014	797	872	1,169	1,195	2,852	1,342	1,272	1,106	674
Smallpox	5	14	1	2	0	0	0	26	76	0
Typhoid Fever	149	130	128	89	81	102	44	80	132	140
Whooping Cough	507	1,082	2,229	1,070	1,505	422	2,012	982	1,296	1,822
Gonorrhea	1,412	1,051	1,152	1,147	1,075	1,096	989	912	872	1,099
Syphilis	622	595	594	475	371	406	462	619	588	464
Tuberculosis	589	594	428	499	525	602	582	552	570	546

*These figures do not include Indians.

Reporting. Physicians are required by law to report cases of communicable disease. With the exception of venereal diseases, which are reported directly to the Department of Health and Public Welfare, they are reported first to the medical health officer who in turn reports them to the Division of Disease Prevention. Prompt and complete reporting is fundamental to an efficient communicable disease control program. Granted that judging the completeness of morbidity reporting by the fatality rate may not be entirely sound, it is still the best method available. According to the standard set up in the Appraisal Form for Local Health Work,* which is based upon the achievement of the upper quartile of communities for which data were available, Manitoba has a highly creditable morbidity reporting record. For example, the standard of reporting for the previous five years for typhoid fever is 8 cases per death; Manitoba reported 8.09. The standard for diphtheria is 13; Manitoba reported 20. The standard for whooping cough is 50 and Manitoba reported 57.9 per annual death.

Records. Reporting cases and deaths and keeping records are useless procedures if the accumulated data are not utilized. They should be analysed and studied side by side with the problems to which they refer. For example, a study of typhoid fever reported from the eight areas in the Province for the five years, 1936 to 1940, inclusive, shows a range in cases per 100,000 population from a low of 5.9 in the West Central area to a high of 47.9 in the Eastern area. A further breakdown of the areas with high case rates reveals that certain communities in the areas have a few cases year after year. This would seem to indicate the presence of endemic foci of the disease and the need for the application of rigorous control measures.

TYPHOID FEVER CASE RATES

Area	Population	Cases, 5 yr. Average 1936-1940	Case Rate per 100,000 pop.
Greater Winnipeg	286,472	20.0	7.0
Eastern Area	56,794	27.2	47.9
Interlake Area	50,360	15.4	30.6
South Central Area	73,700	16.4	22.2
Southwestern Area	77,417	6.6	8.5
West Central Area	64,517	3.8	5.9
Northwestern Area	64,411	5.4	8.4
Northern Area	25,208	5.6	22.2
TOTAL	698,879		14.4

The control of typhoid fever illustrates the importance of a joint epidemiologic approach by physician, public health engineer,

*"Appraisal Form for Local Health Work," 1938, prepared by the Committee on Administrative Practice of the American Public Health Association.

and laboratory staff in the study of communicable disease problems. The typhoid carrier is an important factor in the spread of this disease. Each case should be carefully investigated by physician, engineer and laboratory staff to determine the carrier or other source of infection. Known carriers should be kept under careful supervision.

For the ten-year period, 1930-1939 inclusive, a total of 1,024 cases of typhoid fever with 118 deaths were reported in Manitoba. Studies of recovered cases of this disease indicate that approximately three per cent of cases remain permanent carriers. It might reasonably be expected, therefore, that 31 of the 1,024 cases reported in Manitoba during the past ten years would have remained carriers, yet there are only eleven carriers listed in the Division of Communicable Disease typhoid fever registry.

A second instance of the importance of studying records is found in the analysis of diphtheria cases reported by areas of the Province presented in the table given below.

DIPHTHERIA CASE RATES

Area	Population	Cases 5 yr. Average 1936-1940	Case Rate per 100,000 pop.
Greater Winnipeg	286,472	136.4	47.6
Eastern Area	56,794	30.4	53.5
Interlake Area	50,360	11.6	23.0
South Central Area	73,700	16.2	22.0
Southwestern Area	77,417	4.2	5.4
West Central Area	64,517	4.6	7.1
Northwestern Area	64,411	3.6	5.6
Northern Area	25,208	15.6	61.9
TOTAL	698,879		31.9

The case rates per 100,000 population ranged from a low of 5.4 in the Southwestern Area to a high of 61.9 in the Northern Area. It is of interest to note that the highest morbidity rates are in areas where very little effort has been made to educate the public as to the importance of protecting children early in life from this disease.

Satisfactory immunizing agents are available for several diseases. Smallpox and diphtheria could be decreased to the vanishing point by this method of control. For the ten-year period 1930-1939 inclusive, there has been an annual average distribution of sufficient toxoid to protect approximately 20,000 children against diphtheria. This far exceeds the annual number of births. Two conclusions are self-evident: first, that diphtheria toxoid has been distributed without careful supervision and a certain amount wasted and, second, that the major emphasis of the immunization program

has been placed on school children instead of the younger age groups where most of the cases and deaths occur. This deduction would seem justified by the fact that in 1939 approximately 50 per cent of the cases occurred in children under ten and 43 per cent of the deaths in children under five years of age.

It is recommended:

1. THAT THE DIVISION OF DISEASE PREVENTION BE REORGANIZED AND BE KNOWN HENCEFORTH AS THE BUREAU OF DISEASE CONTROL, AND THAT IT INCLUDE DIVISIONS FOR THE CONTROL OF ACUTE COMMUNICABLE DISEASE, VENEREAL DISEASE, AND PROVISION FOR THE EVENTUAL ESTABLISHMENT OF A DIVISION FOR THE OTHER DISEASES.

2. THAT THE SYSTEM OF RECORD KEEPING IN THE DIVISION OF COMMUNICABLE DISEASE BE REORGANIZED. (See recommendation in the Section on Statistics and Records.)

3. THAT A MORE EFFECTIVE ANALYSIS OF COMMUNICABLE DISEASE RECORDS BE MADE AND USED AS A BASIS FOR DEFINITION OF PROBLEMS, EVALUATION OF SERVICES AND PROGRAM PLANNING.

4. THAT THE IMPORTANCE OF A JOINT EPIDEMIOLOGIC APPROACH OF THE MEDICAL, ENGINEERING AND LABORATORY SERVICES BE STRESSED IN THE CONTROL OF COMMUNICABLE DISEASES.

5. THAT THE DISTRIBUTION OF BIOLOGIC PRODUCTS BE MORE CAREFULLY SUPERVISED.

6. THAT THE EMPHASIS OF THE IMMUNIZATION PROGRAM BE SHIFTED FROM THE SCHOOL TO THE PRESCHOOL GROUP.

Venereal Disease Control. The provincial venereal disease control program is administered under the Division of Communicable Diseases. The staff consists of a Director of Venereal Disease Control who has had special training in this field, and one clerk. The budget is $26,900.50. This includes $4,600.50 for salaries, $900.00 for supplies, $400.00 for travel and $21,000.00 for drugs.

The Province-wide clinic at St. Boniface Hospital is operated as a special clinic of the outpatient department. Although con-

ducted and supervised by the Provincial Department of Health and Public Welfare, it is staffed for the most part by hospital personnel. One senior intern, six junior interns and sixteen hospital nurses devote a portion of their time to the venereal disease clinic. Four sessions are held weekly, two for men and two for women, one each at night. Two nurses from the Division of Public Health Nursing are assigned to venereal disease control activities. One attends the clinics and the other visits the two custodial homes for girls, one of which is Catholic and the other Protestant. Both nurses do follow-up work in the home and elsewhere. Two additional nurses from the Division of Public Health Nursing have recently been detailed to areas adjacent to military cantonments. It is their duty to investigate known or possible sources of infection reported by military authorities or private physicians.

The venereal disease control problem in Manitoba as shown by the following table is of sufficient magnitude to justify a separate Division.

Reported Cases of Syphilis and Gonorrhea
Manitoba, 1930-1939, incl.

Disease	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939
Syphilis	555	623	595	394	475	371	406	463	619	588
Gonorrhea	1650	1418	1051	1152	1147	1075	1096	989	913	872
TOTAL	2205	2041	1646	1546	1622	1446	1502	1452	1532	1460

Reporting. Regulation 30 under the Public Health Act requires that every physician who treats, administers to or prescribes for any person suffering from venereal disease shall report the case within twenty-four hours to the Minister of Health and Public Welfare. This regulation is open to criticism on two points: first, neither the name nor the address of the patient is required on the report card, and, second, in areas with full-time health officers the case should be first reported to the local health officer who should then forward it to the Deputy Minister.

It is difficult to judge the completeness of the reporting of syphilis and gonorrhea in Manitoba. In 1939 the report rate per 100,000 population for syphilis was 84 and for gonorrhea 125. This is low as compared to other parts of the North American Continent having similar population characteristics. The discrepancy may be due to weakness in the case-finding part of the program rather than in the reporting, or possibly in both.

The success of the venereal disease program must depend to a large degree upon the effectiveness of educational activities. This part of the provincial program is weak. Lectures and talks have been given, films shown and literature distributed, but there is no

organized plan for keeping the medical profession in touch with current problems and progress in the field, and for interpreting to the public the nature, cause, methods of spread and cure of these diseases. The most commendable point of the present program is the feature of direct instruction. A conscientious effort is made by the professional staff to see that all patients are fully informed concerning all aspects of their infection.

Case-Finding Epidemiology. The most productive source of case-finding is careful epidemiological investigation of all known cases and contacts. The investigation covering patients attending the St. Boniface Clinic is good. The epidemiological service rendered to private physicians is poor except for aid given in getting lapsed cases back under treatment. The two public health nurses assigned to the Winnipeg area are doing excellent work.

All female persons apprehended on certain charges by the police in the cities of Winnipeg, Brandon and St. Boniface, and in the municipalities of St. James and St. Vital are held for examination for possible infection with syphilis or gonorrhea or both. In the City of Winnipeg male persons apprehended on certain charges are also examined for venereal diseases. Female persons apprehended on charges of vagrancy are also examined for venereal disease infection at other provincial institutions.

Treatment. Free drugs are provided by the Province for treatment of medically needy persons infected with syphilis. Since September 1, 1938, the Dominion Department of Pensions and National Health has provided most of the arsenicals. The Province operates treatment clinics at the following locations:

St. Boniface Hospital	St. Boniface
Detention Home	West Kildonan
Home of the Good Shepherd	West Kildonan
Manitoba Home for Girls	West Kildonan
Brandon Gaol	Brandon
Portage la Prairie Gaol	Portage la Prairie
Provincial Gaol	Headingly

The Clinic at St. Boniface is for patients from the entire Province; however, most of the admissions are from Greater Winnipeg. The other clinics are for the treatment of inmates of the institutions only. In addition to the clinics, the Province pays to physicians a nominal fee for the treatment of needy persons infected with syphilis in parts of the Province not accessible to clinics. It is recognized that more diagnostic treatment stations are needed, and the following locations, in each of which there is a general hospital, have been suggested:

Dauphin	The Pas
Brandon	Flin Flon
Portage la Prairie	Sherridon

Local Participation. The Manitoba venereal disease control program has made much progress and is doing some excellent work. One feature of the program which deserves criticism is that it is administered entirely by the Province, with no local participation. The staff of the Division of Venereal Disease should function so far as possible in an advisory-supervisory capacity and local services be given by local health officials.

There are four full-time health units in Manitoba and others have been recommended. As rapidly as possible the venereal disease control activities should be released to local full-time health departments. The City of Winnipeg should assume full responsibility for its venereal disease control activities.* The field work for St. James-St. Vital and St. Boniface should be referred to the health departments in those areas. The shifting of responsibility from the Province to the local unit will give the staff of the provincial division more time to develop its advisory functions in relation to local programs and more effective educational activities.

Records. A properly kept central registry with full information concerning cases and contacts is essential to a successful venereal disease control program. The registry should be reviewed at frequent intervals and an analysis made of accumulated data as an aid to defining problems, evaluating services and planning programs.

Legislation. There is no law in Manitoba requiring prenatal and premarital examination of the blood for possible syphilitic infection. It would not seem advisable to attempt to have such legislation enacted at the present time because the educational program has not yet created a sentiment for such legislation among the people of the Province. However, such laws should be considered for the future.

Although there is no law requiring the installation of a prophylactic in the eyes of the newborn by physicians, midwives or other persons attending deliveries, 97 per cent of infants born in Manitoba in 1940 had this treatment to prevent disease resulting from possible infection during passage through the birth canal. This is a high achievement; nevertheless, it would be desirable to enact a law making this procedure mandatory.

A marked increase in venereal diseases might have been expected with the establishment of military camps and the influx of soldiers from rural areas following the declaration of war. However, this has not been found, and comparatively few cases have been reported among the military forces. This is probably

*For a full report of the City of Winnipeg, see "Public Health Activities in Winnipeg —1941."

due to the education of the soldiers by military authorities, and to some extent to the control of sources of infection. Nevertheless this is a potential danger, and control measures should be intensified rather than relaxed.

It is recommended:

1. THAT A DIVISION OF VENEREAL DISEASE CONTROL BE CREATED IN THE BUREAU OF DISEASE CONTROL. (See Organization Chart, page 26A.)

2. THAT REGULATION 30 (1) BE CHANGED TO READ: "EVERY PHYSICIAN WHO TREATS, ADMINISTERS TO OR PRESCRIBES FOR ANY PERSON SUFFERING FROM VENEREAL DISEASE SHALL REPORT SUCH CASE WITHIN TWENTY-FOUR HOURS TO THE MINISTER OF HEALTH AND PUBLIC WELFARE, EXCEPT THAT IN AREAS HAVING A FULL-TIME HEALTH OFFICER, THE REPORT SHALL BE SENT TO THE LOCAL HEALTH OFFICER WHO IN TURN SHALL FORWARD IT TO THE MINISTER"; THAT, FORM "1" USED IN REPORTING VENEREAL DISEASES BE CHANGED TO INCLUDE THE NAME AND ADDRESS OF THE PATIENT.

3. THAT THE STAFF OF THE DIVISION OF VENEREAL DISEASE CONTROL PLAN JOINTLY WITH THE BUREAU OF HEALTH AND WELFARE EDUCATION A PROVINCE-WIDE VENEREAL DISEASE EDUCATION PROGRAM.

4. THAT ADDITIONAL DIAGNOSTIC-TREATMENT STATIONS BE MADE AVAILABLE IN OUTLYING PARTS OF THE PROVINCE.

5. THAT THE RESPONSIBILITY FOR ADMINISTERING VENEREAL DISEASE CONTROL SERVICES BE SHIFTED AS RAPIDLY AS POSSIBLE FROM THE PROVINCE TO THE LOCAL UNITS; THAT AFTER JANUARY 1, 1942, WINNIPEG ADMINISTER ITS OWN VENEREAL DISEASE CONTROL PROGRAM; AND THAT VENEREAL DISEASE FOLLOW-UP WORK IN OTHER AREAS HAVING FULL-TIME HEALTH SERVICE BE CONDUCTED BY THESE LOCAL UNITS.

6. THAT AN ADEQUATE SYSTEM OF RECORD KEEPING BE INSTALLED. (See Recommendation in Statistics and Records.)

7. THAT A MORE EFFECTIVE ANALYSIS AND USE OF RECORDS BE MADE AND USED AS A BASIS FOR DEFINITION OF PROBLEMS, EVALUATION OF SERVICES AND PROGRAM PLANNING.

Tuberculosis. The major part of the tuberculosis control program is administered by the Manitoba Sanatorium Board. The activities of this Board are discussed in a separate section. The Department of Health and Public Welfare maintains a tuberculosis registry for the entire Province at the Central Clinic in Winnipeg. The Central Registry is excellently conducted by a well-qualified tuberculosis consultant nurse. The field follow-up work for tuberculosis patients is referred to the provincial public health nurses except in areas with full-time health service where it is conducted by the local health department. The public health nurses of the Provincial Department assist with the traveling tuberculosis clinics.

Cancer. The Provincial Department of Health and Public Welfare has assumed no responsibility in the cancer control program except that one public health nurse has been loaned by the Division of Public Health Nursing to the Cancer Relief and Research Institute. The activities of this agency are discussed in a separate section.

Diabetes. The Provincial Department of Health and Public Welfare distributes insulin to medically needy persons with diabetes.

MATERNAL AND CHILD HEALTH

Maternal Health. The present Division of Maternal and Child Hygiene is a division in name only. The staff consists of the Director, who is a physician with a diploma in Public Health, and a part-time clerk. The Director is also the Director of the Division of Health Education. She devotes the major part of her time to health education activities which include the dissemination of considerable information concerning maternal and child health. She gives physical examinations to young adult groups and assists with immunization clinics.

The Division budget is $2,401.75. It includes $1,101.75 for salaries, $1,050.00 for supplies and $250.00 for travel.

The average yearly provincial maternal mortality rate for the past five years was 3.8 per thousand live births. By areas the highest rate was 5.3 in unorganized territory.

An adequate maternal health program should provide medical, nursing, and hospital care.

While municipal doctors do considerable antepartum and postpartum work, neither the provincial nor the local health departments in Manitoba have conducted any really adequate programs for the protection of maternal and child health. Definite interest in and need for a comprehensive program, however, has been clearly indicated in a splendid study of maternal welfare, the field work for which was completed on April 30, 1940. This was a joint project, sponsored, financed and conducted by the International Health Division of the Rockefeller Foundation, the Canadian Medical Association, the Department of Pensions and National Health, and the Manitoba Department of Health and Public Welfare. The final report will probably be available early in 1942 and will include over 22,000 records of pregnancy. A preliminary, partial report covering 10,600 records was made by Doctor F. W. Jackson, Deputy Minister of Health and Public Welfare of Manitoba at the annual meeting of the Canadian Medical Association in Winnipeg, June 26, 1941.*

The report was discouraging in one respect in that it showed that adequate prenatal care (as defined in the report) was given in only 17 per cent of the 10,600 pregnancies considered. On the other hand death rates were not excessively high. The maternal mortality rate for mothers having adequate prenatal care was 3.8 and for the others 4.6. Death rates of offspring (prenatal and neonatal) were 36.0 per thousand live births for infants whose mothers received adequate prenatal care, and 44.0 in the remaining cases.

Among other significant facts brought out in this report were two of special interest. One is that 73 per cent of all cases was hospitalized. Considering the rural character of Manitoba this is a remarkably high figure. The second point, worthy of special commendation, is that of the 11,657 births attended by physicians, records for 10,600, or 91 per cent, were completed and sent in. This splendid evidence of cooperation on the part of Manitoba's physicians augurs well for the success of whatever programs may eventually be developed for maternal and child health protection.

The preliminary report made by Doctor Jackson included three major recommendations:

"1. That organized medicine, namely, the Canadian Medical Association, through its Maternal Welfare Committee, should set up a minimum standard of prenatal care.

"2. That the Canadian Medical Association must take as its responsibility the education of the medical profession of Canada in

*"Some Observations on Maternal Welfare", by Dr. F. W. Jackson. A paper read at the Seventy-second Annual Meeting of the Canadian Medical Association, Winnipeg, June 26, 1941.

respect to the necessity and desirability of such a minimum standard.

"3. That this standard, when set up, be placed in the hands of official public health agencies with the request that an intensive program be inaugurated to try to insure that a high percentage of pregnant women receive a proper standard of care."

There are 550 physicians in Manitoba, of whom 300 are in Winnipeg. A large percentage of these physicians give obstetrical care. The quality of obstetrical care could be improved by providing refresher courses in this field for the doctors of the province. The value of such courses has been frequently demonstrated.

There is approximately one public health nurse to each 9,400 persons in the province. A certain portion of the nurse's time is necessarily devoted to prenatal services. In 1940 there were 1,014 home nursing visits by public health nurses of the Provincial Department to prenatal cases. The public health nurse is the connecting link between doctor and patient and should participate in the operation of prenatal clinics. She is a valuable case finding agent and should have information concerning all of the prenatal cases in her area. The success of the nursing activities in this field will depend largely upon how well the medical part of the program is developed.

Complete information is not available as to the extent or quality of hospital facilities for obstetrical care. Facilities for obstetrical care should be one of the points taken into consideration in grading hospitals.

Child Health. Control of the general factors determining health and welfare is a necessary foundation for a successful child health program. There must be a safe water and milk supply, adequate sewage disposal, education and recreation facilities and, most important, a happy and economically secure family background. The child health activities should include more than just health education, medical conferences and nursing visits. All of the resources of the province, including preventive medicine, curative medicine and welfare should be mobilized for a joint approach to the solution of the problems of infancy and childhood.

The general provisions of the child health program should be designed for all infant, preschool and school children in the province, and extend from the prenatal stage through adolescence without interruption.

The infant mortality rate is high in Manitoba compared with some other areas having similar population groups. The average

death rate per thousand live births for the period of 1936 to 1940 inclusive, ranged from 47 in towns of over one thousand to 104 in unorganized territory. The rate in the area covered by municipal doctors is 58; for the entire province, it is 56. An analysis of infant deaths by cause and age should indicate specific problems and point the way for program planning.

In much of the province the only Health Department service rendered directly to infants and young children is by the public health nurse. During 1940 Provincial Department nurses made home visits to 2,609 infants and 5,228 preschool children. Nursing service can not function completely without medical supervision. The nurse needs the medically supervised conference or the private physician as the starting point, and the physician needs the nurse's home visit to aid in carrying out his instructions.

Information is not available as to how many infants and preschool children are under the supervision of private physicians. Medically supervised well-child conferences are held in areas with full-time health services except Winnipeg. Nurse supervised well-child conferences are conducted in a number of places in the province.

School Health. A properly planned and executed school health program will be one of the most productive divisions of the total health program. The school child is at a plastic and receptive age. Health habits should be formed during this period which will pay dividends throughout life. The importance of the teacher in the health education program should be stressed. Teachers should have training in teaching health as part of their professional preparation. School health programs should be realistic and planned in relation to the general health program. Teachers should ask themselves: What are the health problems with which my pupils will be faced? Information concerning such problems should be included in the curriculum. The school health program, apart from formal teaching, should be under the direction of the local health department.

The school child should have a physical examination at least twice during the school period and at other times as indicated. The first examination should be given just before entering school or during the first school year, the second a year or two before the child leaves school. The second examination will give the doctor an opportunity to see if defects found at the first examination have been corrected, and to discover and advise concerning new conditions which may have developed. The physical examination ought to be an educational experience for the child and for the parent (who should be present).

The public health nurse is indispensable to the school health program, where her function is primarily that of an educator.

Among other duties she must help interpret the doctor's findings and advice to pupil, parent and teacher. It is her responsibility to follow up the child with remediable physical defects to be sure that they are corrected. There is a tendency in some areas to depend upon the nurse for first aid in minor emergencies. This is a waste of valuable professional time and should not be permitted.

The correction of remediable physical defects begun in the preschool years should be continued throughout the school period. In Manitoba, for the year ending June 30, 1940, the Provincial Department nurses assisted with the medical examination of 14,396 school children mostly from rural areas. Of this number, 6,721, or 39 per cent, were found to have physical defects. Information is not available as to how many of these defects are being corrected. The high per cent of physical defects among young men inducted into military service would indicate that the program for the correction of defects among school children had not been effective hitherto.

Immunization. As remarked in the section on Communicable Diseases, the immunization program is not well planned. The dangerous age for diphtheria is in the preschool years, yet the emphasis of the program is placed on the school child to the neglect of the important group. In 1940 Provincial Department nurses assisted physicians in giving 42,383 toxoid inoculations. This was largely a waste of time and of taxpayers' money as these children should have been immunized as soon as possible after the age of nine months. Instead of giving 42,383 inoculations of toxoid largely to school children, they should have immunized the approximately 13,000 children in the province who reached the age of one year in 1940.

The following table, while based only on readily available records which gave ages, presents further evidence of the need for more preschool immunizations:

MANITOBA DEPARTMENT OF HEALTH AND PUBLIC WELFARE

Diphtheria Immunization, 1940

Districts	School Children Immunized 6-15 years	Per Cent of Total	Preschool Children Immunized 1-5 years	Per Cent of Total
Municipal Doctor Areas	429	73.7	153	26.3
Suburban Areas (City of Winnipeg)	926	85.3	159	14.7
Towns and Villages	328	75.1	109	24.9
City of Portage la Prairie	672	73.3	245	26.7
Rural Municipalities	3,075	71.0	1,260	29.0
Unorganized Territory	865	69.6	378	30.4
Brandon Health Unit	142	51.3	135	48.7
TOTAL	6,437	72.7	2,439	27.3

Dental Health. In the field of dental health the preschool child is again neglected. Dental facilities have been made available to school children by the Canadian Foundation for Preventive Dentistry. Among 14,396 school children receiving physical examinations in 1940, a total of 5,350, or 37 per cent, were found by school physicians to have defective teeth.

Mental Hygiene. The care of persons with mental disease is a great financial burden to the province. A substantial reduction of such disease could be effected by early preventive care, as potential mental cases can frequently be discovered early in life. Mental hygiene services should be provided for such persons while there is hope of preventing actual disease. Such services are lacking in most parts of the province.

Local Programs. The most important function of the staff of the Provincial Department of Health and Public Welfare in the field of Maternal and Child Health is to act in an advisory-supervisory capacity in helping local communities to plan effective programs in this field. As rapidly as local areas are able to assume the responsibility, the Department should turn over to them services now performed by the Province.

It is recommended:

1. THAT THE MATERNAL AND CHILD HEALTH ACTIVITIES OF THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE BE REORGANIZED UNDER A BUREAU TO BE KNOWN AS THE BUREAU OF MATERNAL AND CHILD HEALTH.

2. THAT A PUBLIC HEALTH PHYSICIAN, WITH TRAINING IN OBSTETRICS AND PEDIATRICS BE APPOINTED AS DIRECTOR OF THE BUREAU OF MATERNAL AND CHILD HEALTH.

3. THAT REFRESHER COURSES BE PROVIDED ON A REGIONAL BASIS FOR MANITOBA PHYSICIANS WHO DO OBSTETRICAL WORK.

4. THAT THE MATERNAL WELFARE STUDY, NOW NEARING COMPLETION, BE USED AS THE BASIS FOR DEVELOPING AN ADEQUATE MATERNAL HEALTH PROGRAM.

5. THAT FACILITIES FOR OBSTETRICAL CARE BE ONE OF THE POINTS CONSIDERED IN GRADING HOSPITALS.

6. THAT THE DIRECTOR OF THE BUREAU OF MATERNAL AND CHILD HEALTH TAKE THE INITIATIVE IN COORDINATING CHILD HEALTH AND WELFARE ACTIVITIES OF GOVERNMENTAL DEPARTMENTS, OFFICIAL AND NON-OFFICIAL AGENCIES AND INDIVIDUALS INTO A PROVINCE-WIDE PROGRAM.

7. THAT A STUDY OF INFANT MORTALITY, INCLUDING AN ANALYSIS OF THE CAUSES OF DEATH, BE MADE TO SERVE AS A BASIS FOR DEFINITION OF PROBLEMS, EVALUATION OF SERVICES AND PROGRAM PLANNING.

8. THAT THE TEACHING OF HEALTH IN NORMAL SCHOOLS, MANITOBA UNIVERSITY AND PUBLIC SCHOOLS BE STUDIED AND EVALUATED WITH SPECIAL REFERENCE TO SUBJECT MATTER AND TEACHING METHODS AND TECHNIQUES.

9. THAT AN EFFECTIVE PROGRAM FOR THE CORRECTION OF REMEDIABLE PHYSICAL DEFECTS OF SCHOOL CHILDREN BE PLANNED AND EXECUTED.

10. THAT PROTECTION AGAINST DIPHTHERIA AND SMALLPOX BY IMMUNIZATION BE A PUBLIC SCHOOL ENTRANCE REQUIREMENT.

11. THAT DENTAL FACILITIES BE MADE AVAILABLE TO PRESCHOOL CHILDREN AND THAT DENTAL SERVICES FOR SCHOOL CHILDREN BE INCREASED.

12. THAT A MENTAL HYGIENIST BE ADDED TO THE STAFF OF THE BUREAU OF PUBLIC HEALTH NURSING AND MADE AVAILABLE TO LOCAL COMMUNITIES ON A CONSULTATION BASIS.

13. THAT THE BUREAU OF MATERNAL AND CHILD HEALTH PLACE MAJOR EMPHASIS UPON HELPING LOCAL AREAS AND COMMUNITIES PLAN THEIR OWN PROGRAMS, RATHER THAN GIVING DIRECT SERVICES.

PUBLIC HEALTH NURSING

The Division of Public Health Nursing is one of the oldest in the Department of Health and Public Welfare, having preceded the establishment of any of the medical services in the Department.

Present personnel consists of a well-qualified and experienced director, a well-trained assistant director and educational supervisor, a tuberculosis nursing consultant (loaned to the Manitoba Sanatorium Board), a cancer nursing consultant (loaned to the Cancer Relief and Research Institute), two generalized supervisors, one nurse giving classes in Home Nursing, First Aid and Child Care to community groups throughout the province, and 34 field nurses, making a total of 41.

Expenditures for the Division are approximately $75,635.00, representing 30.5 per cent of total public health expenditures by the Department of Health and Public Welfare. (See Table, page 26A). Of this amount $57,035.00 is for salaries, $15,400.00 for travel, and $3,200.00 for supplies, drugs, equipment, et cetera.

The distribution and functions of the nurses in the field are most unusual. The distribution is as follows:

(a) Eight are assigned to districts in unorganized or disorganized territory. In general these districts are on the periphery of the Province, each comprising an area of about 900 square miles with a population of from one to four thousand. They conduct a generalized public health nursing program with demonstration nursing service but not bedside care. Because of the difficulties of transportation and the distances between calls, the service can not be as effective as in more populous areas. Home teaching, prenatal and preschool services are relatively weak. Group instruction is not attempted because of the sparse population. The services of these nurses are paid for entirely by the Province.

(b) Three nurses in unorganized or disorganized territory carry on essentially a bedside nursing service. Their districts, with one exception, are smaller in area than the generalized public health nursing districts of the eight nurses referred to in the preceding paragraph but have similar populations. The services of these nurses are paid for solely by the Province although a tax levy furnishes approximately 30 per cent of the nurse's salary and the local area assists in the operation and maintenance of the nurse's station.

If it costs $1,800.00 per year for a nurse's services, and this is probably below the average, then in these disorganized territories, the Province is paying at the rate of from 45 cents to $1.80 per capita to supply a nursing program which, except possibly in two smaller districts, is not at best a completely adequate service. Unquestionably this is expensive, particularly when one considers the time consumed in travel.

(c) Four nurses are known as roving nurses. The name "roving" seems particularly accurate in describing their activities. These are senior nurses working in very large organized areas. The district of each nurse comprises from 19 to 30 municipalities and is roughly 80 by 180 miles. Population varies: 59,000 in one district, 64,600 in a second, a third with 68,800 and the fourth 117,300. The services of these nurses are paid for entirely by the Province.

Roving nurses do not attempt to conduct a generalized service. Their functions are largely:

1. To arrange for and assist at all communicable disease prevention, including chest and dental, clinics. In one district mental hygiene clinics are also included.
2. Tuberculosis follow-up work.
3. Health supervision of Boarding Homes for children, Homes for the Aged and Infirm, Maternity Homes, and Homes for Evacuee Children.
4. To visit all areas where outbreaks of disease occur.
5. To render a limited amount of assistance to physicians in school medical examinations and tuberculin-testing.

The following estimates of the time spent on various services by the roving nurse have been made from the 1940 annual reports of the three roving nurses who were on duty that year:

Estimated Division of Roving Nurse's Time in 1940

Total working days (3 nurses), 759

Type of Work	Days Spent	Per Cent of Time
Disease Prevention Clinics	163.5	21.5
Chest Clinics	62.0	8.2
Dental Clinics	51.0	6.7
Total Clinics	276.5	36.4
Visits to or in behalf of tuberculosis*	177.0	23.3
Legal Responsibilities—		
Visits to Boarding Homes for Children*	34.2	4.5
Visits to Homes for Aged and Infirm*	7.5	1.0
Visits to Maternity Homes*	5.3	0.7
Total Legal Responsibilities	47.0	6.2
Visits to Evacuee Children*	107.8	14.2
Miscellaneous visits*	141.6	18.7
Other services	9.1	1.2
GRAND TOTAL	759.0	100.0

*Visits have been translated into days of work on the basis of 10 visits per day

These figures include travel in the day's work. Mileage traveled by the three nurses working in 1940 ranged from a low of 10,684 per annum to a high of 17,344. Even the low of 10,684 is considerable when one realizes that in this area, the Northwest District, driving was impossible during three months and parts of two others. The nurse in the Western District traveled 15,162 miles, which is between the high and low. This nurse spent 96.5 days in travel, or 38.1 per cent of the total year's work. Since this district is not the largest and the mileage is neither the high nor the low, it seems safe to say that at least 35 per cent of the roving nurse's total working time is spent in travel.

Per capita wealth in the four districts varies from a low of $398.00 in District D, the Eastern District, to a high of $1,017.00 in District B, the Western District.

In District A, the Northwest District, per capita wealth averages about $500.00 and ranges from a low of $207.00 to a high of $930.00. The district includes 19 municipalities.

District B, the Western District, has an average per capita wealth of $1,017.00, ranging from $459.00 to $1,522.00. There are 30 municipalities in the area.

District C, the Central District, averages about $859.00 per capita, the range being from $269.00 to $1,597.00. This district includes 30 municipalities.

District D, the Eastern District, has an average per capita wealth of about $398.00 and the range is from $151.00 to $763.00. There are 20 municipalities in the district.

It is indeed difficult to justify this roving nurse service. Certainly it can not be defended on the basis of legal responsibilities which occupy only 6.2 per cent of working time. It would be far cheaper to send a nurse into the area for two or three weeks to perform this function in one journey. It could hardly be approved on the basis of assistance at clinics since this requires only 36 per cent of total hours.

The only basis upon which the service might conceivably be worth while is in considering clinic assistance and tuberculosis follow-up together. These combined functions occupy approximately 60 per cent of the nurse's working time. Even then it is difficult to justify a service in which over 35 per cent of total time is spent in travel.

However, the strongest arguments against it are: First, that it is not a comprehensive generalized public health nursing service, and second, that it is rendered in organized areas which on the basis of per capita wealth are well able to pay for nursing service if they want it, with the exception of certain parts of District D, the Eastern area.

(*d*) Specialized nursing services are carried on by five nurses in Winnipeg and its suburbs. Two nurses render health supervision services for Children's Boarding Homes, Day Nurseries and other child care institutions. One provides the health supervision for Private Boarding Homes and Institutions for the Aged and Infirm, and two are assigned to venereal disease work. A sixth nurse, to teach health in the Normal Schools, is to be added to the staff this fall. As stated in the report on "Public Health Activities in Winnipeg", these services, except for health teaching in Normal Schools (which should be provided by the Department of Education), should eventually be taken over by the Winnipeg City Health Department. At present the services of all these nurses are supplied by the Province without cost to the City of Winnipeg or its suburbs.

(*e*) Fourteen nurses are engaged in organized areas, each providing a generalized public health service to a district of from one to three municipalities. Each district pays $700.00, or slightly more than 30 per cent of the cost of the service. Because the districts are smaller and the local community participates in its financing, this service appears to be more comprehensive and intensive than any of the other public health nursing field services supplied through the Provincial Department of Health and Public Welfare though somewhat weak in prenatal, preschool, and group work. Local communities desiring such service might well be expected to contribute a larger proportion of the cost. Whenever possible, public health

nursing should be supplied in conjunction with full-time health departments rather than as a separate service.

It is significant that of the 34 field nurses of the Department of Health and Public Welfare, 20, or 59 per cent, are being supplied without cost to the local areas they serve. This is an unusually high per cent of direct service. The trend in provincial and state health department practice is, and should be, to provide less direct service, and to assist local areas to do for themselves, and this applies to public health nursing as well as to the whole field of public health service.

There are two generalized field supervisors who spend two weeks in the field with a new nurse introducing her to the service. They also visit each field nurse at least twice a year, except the roving nurses who, being senior nurses, are not supervised.

There are monthly staff conferences but unfortunately, because of the distance, only the nurses in Winnipeg and its vicinity are able to attend.

Every two years all nurses are brought in for a two weeks' refresher course.

Working relationships between the medical and public health nursing service are not as close as they should be. Periodic staff conferences of the executive personnel of the Department should help this situation.

In conformity with the statute, the Division of Public Health Nursing employs no married women.

In addition to the 41 public health nurses of the Provincial Department of Health and Public welfare, six public health nurses are employed by the three full-time health units of St. James-St. Vital, St. Boniface, and Brandon. These nurses are supervised, and must meet the qualifications of training and experience of the Provincial Department. There are 44 nurses in official and voluntary agencies in Greater Winnipeg who, however, have no direct relation to the Provincial Department.

Thus, there are in Manitoba at least 74 public health field nurses. Based on an estimated population of 700,000 for the province, this gives a ratio of one public health nurse to 9,460 persons. (This figure does not include the four roving nurses.)

The nurses of the Provincial Department of Health and Public Welfare should be able to render more effective service to a greater number of people, if the present policy of assigning field nurses were changed.

In order to bring about this improvement and to prevent unnecessary and expensive duplication of travel and service in outlying rural areas on the part of field personnel in public health nursing and social work, it is recommended:

1. THAT THE ENTIRE DEPARTMENT OF HEALTH AND PUBLIC WELFARE, INCLUDING THE PERSONNEL OF THE DIVISION OF PUBLIC HEALTH NURSING, DEVOTE ITS MAJOR EFFORTS TOWARD THE ESTABLISHMENT OF FULL-TIME LOCAL HEALTH DEPARTMENTS.

2-*a*. THAT, AS FULL-TIME LOCAL HEALTH DEPARTMENTS ARE ORGANIZED THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE DISCONTINUE DIRECT SERVICE TO LOCAL AREAS, EXCEPT FOR EMERGENCY AND HIGHLY TECHNICAL FUNCTIONS.

b. THAT, IN ACCORDANCE WITH THIS POLICY, THE ROVING NURSE DISTRICTS BE ABANDONED AND THESE NURSES ASSIGNED TO SMALLER AREAS WHERE THEY CAN CONDUCT A REASONABLY COMPREHENSIVE GENERALIZED PUBLIC HEALTH NURSING SERVICE.

Where possible they should be placed in full-time local health departments, otherwise in organized areas, preferably where there are municipal doctors and where the local community is willing to bear a reasonable share of the expense of the service.

c. THAT, NURSES BE WITHDRAWN GRADUALLY BUT COMMENCING AT THE EARLIEST OPPORTUNITY FROM UNORGANIZED AREAS, AND BE ASSIGNED IN ACCORDANCE WITH THE POLICY OUTLINED IN THE PRECEDING RECOMMENDATION.

d. THAT NURSES WORKING IN THE WINNIPEG AREA AND RECEIVING THEIR ENTIRE SALARIES FROM THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE BE TRANSFERRED TO OTHER AREAS AS SOON AS FEASIBLE IN ACCORDANCE WITH THE PRECEDING RECOMMENDATION.

3. THAT, IN VIEW OF THE EXPENSE INVOLVED IN SENDING SEVERAL PERSONS TO SPARSELY SETTLED AREAS TO RENDER SEPARATE BUT NEVERTHELESS RELATED SERVICES, CONSTITUTING LEGAL RESPONSIBILITIES OF THE

DEPARTMENT, THE DEPARTMENT TAKE IMMEDIATE STEPS TO PREPARE AND TRAIN A COMPLETELY GENERALIZED FIELD STAFF IN PUBLIC HEALTH NURSING AND WELFARE TO FUNCTION IN RURAL AREAS.

4. THAT THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE ENDEAVOR TO DEVELOP A PROGRAM PROVIDING PUBLIC HEALTH TRAINING FOR NURSES IN WHICH THE FINANCIAL BURDEN SHALL BEAR AS LIGHTLY AS POSSIBLE ON THE NURSES.

   Special emphasis should be placed on training nurses to render consultant nursing service in such fields as venereal disease, orthopedics, and school health.

5. THAT THE DIVISION OF PUBLIC HEALTH NURSING ARRANGE REGIONAL INSTITUTES ON PUBLIC HEALTH AND PUBLIC HEALTH NURSING FOR THE BENEFIT OF ITS FIELD STAFF WORKING AT A DISTANCE FROM WINNIPEG.

6. THAT WHEN AN INDIVIDUAL IS ASSIGNED FROM THE DIVISION OF PUBLIC HEALTH NURSING, OR FROM ANY DIVISION, TO WORK OF MORE THAN TEMPORARY DURATION IN ANOTHER DIVISION, THAT THE INDIVIDUAL BE TRANSFERRED TO THE DIVISION IN WHICH THE NEW WORK IS TO BE PERFORMED.

7. THAT THE PUBLIC HEALTH NURSES IN WINNIPEG BE INVITED TO ASSIST IN DEVELOPING AND CONDUCTING A PROGRAM OF PUBLIC HEALTH NURSING STAFF EDUCATION.

8. THAT IN ADDITION TO REGULAR PUBLIC HEALTH NURSING STAFF CONFERENCES, PERIODIC STAFF CONFERENCES BE HELD, AT LEAST EVERY TWO MONTHS, FOR THE PERSONNEL OF THE DIVISION OF PUBLIC HEALTH NURSING AND THE PUBLIC WELFARE STAFF.

9. THAT A CONSULTANT MENTAL HYGIENE NURSE BE APPOINTED TO THE STAFF OF THE BUREAU OF PUBLIC HEALTH NURSING.

10. THAT THE RETIREMENT PLAN BE REVISED TO PERMIT FULL RETIREMENT COMPENSATION AT THE AGE OF FIFTY AND MAKE RETIREMENT COMPULSORY AT SIXTY.

NOTE: For those interested in public health nursing, see also section on Local Health Service, the tables on Medical Health Officers, and Public Health Nurses in Manitoba, and comments relative thereto, pages 94-100.

SECTION OF ENVIRONMENTAL SANITATION

The Section of Environmental Sanitation is to include the Bureaus of Public Health Engineering, Food and Milk Control, and Industrial Hygiene.

PUBLIC HEALTH ENGINEERING

The personnel of the Division of Sanitation of the Provincial Department of Health and Public Welfare consists of the director, who is known as the Chief Sanitary Inspector, a director of Food Control, four sanitary inspectors, one of whom has recently joined the Army, one field milk inspector, one milk technician, and a stenographer, making a total of nine.

The Director of the Division, while not a public health engineer, is a graduate of the British Sanitary Institute and has broad experience in the general field of sanitation. He has been in his present position for many years and commands the respect and confidence not only of his colleagues in the Department but of the people throughout the province.

The Director of Food and Milk Control is a veterinarian experienced in both meat and milk supervision. The four sanitary inspectors all do some milk work and meat and slaughterhouse inspection, in addition to general sanitation.

Although nominally a single division, functionally the Division of Sanitation falls into two sections:—General Sanitation, and Food and Milk Control.

It has been roughly estimated that General Sanitation occupies the full time of the Chief Sanitary Inspector, three general sanitary inspectors and half the time of a stenographer, while the full time of the Director of Food Control, one field milk inspector, one milk technician, one general sanitary inspector and half the time of the stenographer are devoted to Food and Milk Control.

The expenses of the Division are estimated separately because of this functional splitting with $12,515.75 allotted to General Sanitation, of which $7,815.75 is for salaries, $3,500.00 for travel and $1,200.00 for supplies, equipment, et cetera.

With one exception, (where an inspector works out of The Pas and covers the North District), the province is not divided into sanitary inspection districts. From May 1st to August 1st a sanitary inspector was stationed in Brandon to work with the full-time health unit in that city and to serve the surrounding area. This inspector joined the Army and has not as yet been replaced. Other-

wise, the work of sanitation is conducted from the Central Office, the inspectors going to those places from which either requests or complaints have been received.

While visits of general sanitary inspectors are usually predicated upon either requests or complaints, the sanitary inspectors do carry on certain regular inspectoral services, principally in the fields of rural school sanitation, meat and slaughterhouse inspection, limited milk inspections, tourist camp and resort sanitation in the summer, and logging, fishing, hunting and moss camp sanitation in the winter.

Individual items included in the work of general sanitation are too numerous to mention. However, the major efforts in terms of time consumed, include investigating, usually upon request, rural water supplies and sewage disposal systems, rural plumbing and drainage installations, answering complaints, the services mentioned in the preceding paragraph, and the inspection of proposed private hospitals and other private institutions.

It is estimated that of the complaints received, only about ten per cent have any real public health significance.

Nearly all communities, large and small, have public water supplies, but, except for cities, very few communities have public sewage disposal systems.

The Regulations under the Public Health Act are, generally speaking, adequate as they apply to sanitation. However, with the exception of major items, such as public water supply and sewage disposal systems, they vest considerable responsibility and authority in the medical health officer, which unless he is conducting a full-time health department, he appears seldom to accept. There are no regulations requiring a community over a certain size to install both public water and sewage disposal systems.

It is obvious that the limited staff of the Division of Sanitation can not hope to do a comprehensive job for the entire province. There are only three full-time health units outside of Winnipeg, and part-time medical health officers can not be expected, on what the community pays them, to assume responsibility for the broad problems of local sanitation.

Whenever inadequate funds or personnel make it impossible to do a complete job, the question that naturally arises is: How can the efforts of present personnel be employed to do the most good for the most people, pending the time when more ample facilities will be available?

A thorough-going answer to this question is difficult without a careful study of all the possibilities, but one might suggest that every effort be made to have the more populous areas install both public water supply and public sewage disposal systems, to improve existing systems where improvements are needed, and to raise the level of sanitation in schools and other public buildings, particularly with respect to water supply and sewage disposal. Efforts should also be made to reduce to a minimum the number of visits demanded to investigate complaints, most of which have little or no public health significance.

One important need of the Division of Sanitation is for the services of a well-trained and experienced public health engineer. As previously stated, the Chief Sanitary Inspector has had broad experience in the field of sanitation. However, in this field and in industrial hygiene, there are so many highly technical engineering problems concerning water supply and sewage disposal, plumbing equipment, milk pasteurization plants, et cetera, that the services of a public health engineer are necessary if best results are to be obtained.

In order that the efforts of the Division of Sanitation may benefit a greater number of people, and to implement present facilities, it is recommended:

1. THAT THE ACTIVITIES NOW VESTED IN THE DIVISION OF SANITATION BE INCLUDED IN THE SECTION OF ENVIRONMENTAL SANITATION AND THAT THE FUNCTIONS OF THIS SECTION BE CARRIED ON BY THE BUREAUS OF PUBLIC HEALTH ENGINEERING, FOOD AND MILK CONTROL AND INDUSTRIAL HYGIENE. (See Organization chart, page 26A.)

2. THAT A WELL-TRAINED AND EXPERIENCED PUBLIC HEALTH ENGINEER BE ADDED TO THE STAFF OF THE DIVISION OF SANITATION PROBABLY IN THE CAPACITY OF ASSISTANT DIRECTOR.

3. THAT CONSIDERATION BE GIVEN TO REQUIRING UNDER THE REGULATIONS OF THE PUBLIC HEALTH ACT THAT ALL COMMUNITIES OF/OR OVER A CERTAIN POPULATION, PERHAPS 1,000, MUST INSTALL BOTH APPROVED PUBLIC WATER SUPPLY AND APPROVED PUBLIC SEWAGE DISPOSAL SYSTEMS.

4. THAT EVERY EFFORT BE MADE TO:

   (*a*) STIMULATE AND ENCOURAGE ALL COMMUNITIES TO INSTALL BOTH APPROVED

PUBLIC WATER AND APPROVED PUBLIC SEWAGE DISPOSAL SYSTEMS WHERE THEY CAN POSSIBLY AFFORD TO DO SO;

(*b*) IMPROVE EXISTING PUBLIC WATER SUPPLY AND PUBLIC SEWAGE DISPOSAL SYSTEMS THAT ARE IN NEED OF IMPROVEMENT;

(*c*) FURTHER IMPROVE SCHOOL AND OTHER PUBLIC BUILDING SANITATION PARTICULARLY WITH RESPECT TO WATER SUPPLY AND DISPOSAL OF EXCRETA.

5. THAT THE SANITATION DIVISION, IN KEEPING WITH THE RECOMMENDATIONS FOR THE DEPARTMENT AS A WHOLE, RENDER CONSULTATION-ADVISORY FIELD SERVICES, IN DISTINCTION TO DIRECT SERVICE, TO LOCAL FULL-TIME HEALTH DEPARTMENTS NOW IN EXISTENCE OR WHICH MAY BE ESTABLISHED IN THE FUTURE.

FOOD AND MILK CONTROL

The function of the Division of Sanitation as it applies to food and milk is concerned largely with milk control and meat and slaughterhouse inspection.

Since milk control is the principal problem because of its magnitude as compared with the supervision of meat and other foods, it will form the chief subject of this brief discussion.

The staff concerned with Food and Milk Control consists of the Director, one field milk inspector, one milk technician and the equivalent of the time of one sanitary inspector and half time of one stenographer. Expenses are estimated at $9,011.75, of which $7,011.75 is for salaries, $1,500.00 for travel and $500.00 for supplies, equipment, et cetera.

The regulations governing Food and Milk Control under the authority of the Public Health Act are, on the whole, reasonably adequate, but apparently less satisfactory for milk than for meat and other foods. Again, with the exception of certain important items, such as the licensing of slaughterhouses, the pasteurization of milk and the supervision of certified milk, these regulations vest major responsibility and authority in local medical health officers. If the province had adequate coverage of full-time health departments, the program would no doubt function reasonably well. However, with only four full-time and approximately 170 part-time health officers, this means in all probability that outside of full-time

areas, there is practically no local food and milk control except in a few communities where the limited personnel of the Division is able to assist in developing local programs. This situation calls attention strikingly to the need for developing full-time local health services.

Although the milk regulations require a license for pasteurization plans, they do not require tuberculin-testing of dairy herds except those producing certified milk, and no mention is made of Bang's disease testing. There are minimum requirements for butter fat and total solids, but no regulations concerning bacterial counts. The definition of pasteurization does not recognize the new, short-time high-temperature method, nor do the regulations permit pasteurized certified milk.

The existing milk regulations for the province as a whole do not assure a safe, protected milk supply. Apparently, adequate control is dependent largely upon the willingness of local communities to pass milk by-laws. This again points to the need for full-time local health departments.

At present the work of the Division of Food and Milk Control, as it applies to milk, consists of licensing and inspecting the dairies, shipping milk to the ten pasteurizing plants in Greater Winnipeg; inspecting dairies supplying milk to Brooklands, East Kildonan and West Kildonan; and assisting some twelve to fifteen towns and villages which license their local milk vendors. Between 800 and 900 dairies supply milk to the ten pasteurizing plants in Greater Winnipeg, and about 18 dairies to Brooklands, West Kildonan and East Kildonan. Assistance to the twelve or fifteen towns and villages which have passed milk by-laws is given at the request of these communities, and consists of inspecting farms once or twice a year, and making reports to the local health officers. Raw milk peddlers are licensed by local authorities.

The city of Brandon recently instituted a local milk-control program with the assistance of an inspector loaned by the Provincial Department. This inspector has joined the Army and has not been replaced.

This brief description covers fairly well the areas having any milk control programs except that, in addition to the Winnipeg area, some 52 municipalities require tuberculin-testing. Testing for Bang's disease is carried on in Minnedosa and Brandon and in a few small areas in which undulant fever has been reported.

The work in Greater Winnipeg occupies the full time of the field milk inspector and the technician, thus leaving the Director of Food and Milk Control (who obviously has other duties), and

perhaps service equivalent to the full time of one sanitary inspector for all the remainder of the province as far as milk control is concerned.

The Provincial Department of Health and Public Welfare should not provide this service to Winnipeg and its suburbs. The City Health Department ought to furnish milk control for Winnipeg, and in the suburbs local authorities can well afford to set up their own milk inspection with such consultation service as they may need from the Division of Food and Milk Control. Certain it is that the Provincial Department of Health and Public Welfare should not be expected to devote 60 per cent, and probably more nearly 75 per cent, of its total available services to milk control for the largest metropolitan area of the Province—the area which can best take care of its own problems.

It is safe to say that, with the exception of the areas mentioned in preceding paragraphs, the milk supply of the Province is far below what it should be from the standpoint of safety and protection. With the exception of twelve to fifteen towns and villages which are endeavoring to insure the safety of their milk supplies, and the two largest metropolitan areas of the Province, Winnipeg and Brandon, Manitoba is essentially without any machinery for the protection of its milk supply. This results from the fact that while there are certain minimum requirements applying to the production, distribution and sale of milk, local areas with the aforementioned exceptions, make no effort to enforce them.

As a means of developing a more effective program, it is recommended:

1. THAT THE BUREAU OF FOOD AND MILK CONTROL (HERETOFORE RECOMMENDED) TAKE IMMEDIATE STEPS TO TRANSFER THE WORK IT IS NOW DOING IN THE WINNIPEG AREA TO LOCAL AUTHORITIES.

2. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE DIRECT ITS MAJOR EFFORTS IN BEHALF OF MILK CONTROL AND SUPERVISION TO:

   (*a*) STIMULATING AND ENCOURAGING THE LARGER COMMUNITIES TO PASS ADEQUATE MILK BY-LAWS AND ASSISTING THEM IN THE DEVELOPMENT OF THEIR OWN LOCAL MILK CONTROL AND SUPERVISION PROGRAMS, AND

   (*b*) RENDERING CONSULTATION - ADVISORY FIELD SERVICES TO FULL-TIME LOCAL

HEALTH DEPARTMENTS BOTH AS THEY EXIST AT PRESENT AND AS THEY MAY BE ESTABLISHED IN THE FUTURE.

3. THAT THE PROVINCIAL REGULATIONS REGARDING MILK BE REVIEWED AND REVISED TO INCLUDE:

   (a) A REQUIREMENT THAT ALL FLUID MILK TO BE SOLD AS FLUID MILK FOR HUMAN CONSUMPTION MUST COME FROM TUBERCULIN-TESTED HERDS.

   (b) A PROVISION REQUIRING THAT ALL RAW MILK SOLD FOR HUMAN CONSUMPTION MUST COME FROM HERDS TESTED FOR BANG'S DISEASE.

   (c) A REGULATION DEFINING PASTEURIZATION IN SUCH MANNER AS WILL PERMIT THE USE OF SOME OF THE NEWER METHODS.

   (d) A PROVISION RECOGNIZING PASTEURIZED-CERTIFIED MILK.

4. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE INCLUDE IN THEIR CONSULTATION-ADVISORY SERVICE ON FOOD AND MILK CONTROL ASSISTANCE TO LOCAL HEALTH DEPARTMENTS IN DEVELOPING THEIR OWN PROGRAMS FOR THE CONTROL AND SUPERVISION OF MEAT AND OTHER FOODS AND FOOD PRODUCTS.

INDUSTRIAL HYGIENE

Such functions as are now undertaken in the field of industrial hygiene are the responsibility of the epidemiologist. To date, activities have consisted largely of making physical examinations of miners for the Workmen's Compensation Board. While the examination of all persons exposed or possibly exposed to the hazards of silicosis is highly desirable, this does not seem to be a proper function of the Department of Health and Public Welfare. Such examinations, whether to safeguard the health of the individual or to protect the company, should be a responsibility of the Workmen's Compensation Board. On the other hand, a thorough survey and study of contributory conditions as a basis for instituting a program designed to minimize the hazards of silicosis might well be a useful function of the Provincial Department of Health. The

Department's effectiveness in the field of industrial hygiene is at present minimal because of a lack of trained personnel and adequate laboratory equipment.

While industrial hygiene is not yet a problem of paramount importance, the continued advance of industry in Manitoba makes it seem certain that before long there will be need for a Bureau of Industrial Hygiene in the Provincial Department of Health. Since Industrial Hygiene, in addition to dealing with important general health problems of the adult (working) population, involves the control of environmental factors, when the time comes to develop an adequate industrial hygiene service, it is recommended:

1. THAT THE BUREAU OF INDUSTRIAL HYGIENE BE ESTABLISHED UNDER THE SECTION OF ENVIRONMENTAL SANITATION.

2. THAT WHEN A BUREAU OF INDUSTRIAL HYGIENE IS ESTABLISHED, TRAINED PERSONNEL BE EMPLOYED AND ADEQUATE LABORATORY FACILITIES BE PROVIDED.

SECTION OF PSYCHIATRY AND HOSPITALIZATION

The Section of Psychiatry and Hospitalization includes the Bureaus of Psychiatry and Hospital Care.

PSYCHIATRY

The program as it relates to mental disease, mental hygiene and mental defectives, is wholly a provincial program administered through the Division of Psychiatry of the Provincial Department of Health and Public Welfare. No individual community has a local program in these fields.

The personnel of the Division of Psychiatry, exclusive of personnel at the institutions in Brandon, Selkirk and Portage la Prairie, totals six, including the Provincial Psychiatrist, who is the Director, an Assistant Director, an additional psychiatrist, a social service director, an occupational therapist, and a statistical clerk-stenographer.

Expenditures of the Division of Psychiatry, exclusive of the Hospitals for Mental Disease and the Manitoba School for Mentally Defective Persons, total $59,006.00, of which $45,500.00 is for the maintenance of patients in the Psychopathic Ward of the Winnipeg General Hospital, $13,006.00 for salaries, and $500.00 for supplies, equipment, et cetera.

Estimated expenditures for:

The Hospital for Mental Diseases at Brandon	$410,124.00
The Hospital for Mental Diseases at Selkirk	246,512.00
The Manitoba School for Mentally Defective Persons at Portage la Prairie	164,882.50
The Executive Office for Mental Disease	29,895.00
Total	$851,413.50

Thus, with the $59,006.00 for the Psychiatric Division itself, provincial expenditures for psychiatric diagnosis and treatment, hospitals for mental disease and the Manitoba School for Mentally Defective Persons total $910,419.50 or $1.30 per capita, and represents 37 per cent of the total expenditures of the Provincial Department of Health and Public Welfare.

In many respects this is the best administered service in the Department of Health and Public Welfare in spite of the severe limitations of space and facilities. The Provincial Psychiatrist who is in charge is exceptionally well trained and experienced. His assistant, the medical superintendents and their assistants of the

Hospitals for Mental Diseases at Brandon and Selkirk and at the Manitoba School for Mentally Defective Persons in Portage la Prairie are also well trained, capable psychiatrists. Notwithstanding the overcrowding and shortage of beds at both institutions, the Province can take pride in having two excellent Hospitals for Mental Diseases at Brandon and Selkirk.

The Psychopathic Hospital in Winnipeg is doing splendid work, but is hardly able to meet the demand for accommodations. Its services in the field of mental hygiene are excellent but not nearly extensive enough. There is need for an additional occupational therapist. In addition to observation, diagnosis and treatment, the Psychopathic Hospital performs an important and valuable educational service in providing two months of psychiatric training for interns from the Winnipeg General Hospital and training periods for student nurses from that hospital.

The activities of the Brandon Hospital for Mental Diseases are also to be commended but suffer from the same restrictions. The principal reason for the inadequacy of the mental hygiene program is that, far from being covered by a special appropriation, it is undertaken as an extra duty by the already overworked hospital staffs, simply because of the interest of the physicians in rendering this important type of service.

Mental hygiene and psychopathic treatment of hopeful cases stand as the bulwark of defence against prolonged hospitalization. Therefore, expansion of these services would seem to be the most important means of reducing the need for beds for chronic mental patients. Appropriations for mental hygiene and psychopathic care should therefore be considered investments in the prevention of permanent mental disabilities which constitute a severe drain on the finances of the Province.

The Manitoba School for Mentally Defective Persons is well administered but far from achieving the standard of organization and efficiency reached by either of the Hospitals for Mental Diseases. The buildings, except for a new nurses' home, are old and quite unsuited for the proper care of the cases admitted. While changes have been made, and others are under way which will improve the situation slightly, the housing arrangements will still be far from satisfactory.

It is unfortunate that varying degrees of mental defectiveness cannot be segregated. The separation of children and adults seems even more strongly indicated, and certainly epileptics ought to receive separate care.

The name "Manitoba School for Mentally Defective Persons" is a misnomer because it implies that the institution is essentially

for children while, as a matter of fact, the institution was established many years ago as a home for the aged and infirm and apparently has never outgrown its original function. The children are far outnumbered by adults and there are many senile cases who could be transferred if another institution were available. The present waiting list for the "School" includes some 130 boys and 30 girls.

The following table indicates rated bed capacity, beds used, and per cent of overcrowding in the several institutions:

	Rated Bed Capacity	Beds Used	Percent Overcrowding
Psychopathic Hospital, Winnipeg.....	32	31	0
Hospital for Mental Diseases, Brandon....	1,300	1,507	15.9
Hospital for Mental Diseases, Selkirk.....	640	880	40.0

While this shows that there is a difficulty, it does not present the entire picture. Observation, diagnosis and treatment facilities for hopeful cases total 287 beds, including 32 at the Psychopathic Hospital, 125 at Brandon and 130 at Selkirk. The figures do not indicate the heavy concealed pressure on these facilities. This situation requires verbal explanation. The number of beds for hopeful cases is apparently adequate, but this is because only such patients as can be cared for are admitted. There is a "bottle neck" in the reception or diagnostic treatment wards in all three institutions, because of shortage of accommodations for chronic mental cases, which makes it necessary to retain in the treatment wards patients whose prognosis is not hopeful, and who would be transferred to mental disease hospital beds if such were available. This means that hopeful cases are put on waiting lists because accommodations intended for them are occupied by frank mental disease patients. The situation creates a vicious circle in that some hopefuls become chronics before they can be admitted, and this obviously taxes the capacity of the Hospitals for Mental Diseases still further.

There is, in addition, pressing need for an infirmary unit at Selkirk. At present bed patients are scattered throughout the institution and tuberculous patients are not completely segregated. It is not only costly to provide care for bed patients in widely separated parts of the institution, but the lack of facilities for the proper isolation of the tuberculous is dangerous.

It is indeed regrettable to note that raw milk is served to patients at Selkirk. Such use of raw milk in a large public institution, such as the Hospital for Mental Diseases at Selkirk, an institution moreover, which is under the jurisdiction of the Provincial Department of Health and Public Welfare, is of course very undesirable.

Occupational therapy at Selkirk is not nearly so well developed as at Brandon. There is need for at least one additional occupational therapist. As a means of meeting, at least partially, the needs pointed out in preceding paragraphs, it is recommended:

1. THAT AN INSTITUTION OF APPROXIMATELY 250 BEDS FOR CUSTODIAL CARE BE ESTABLISHED, PROBABLY AT PORTAGE LA PRAIRIE, TO WHICH MAY BE TRANSFERRED SENILE CASES FROM BOTH THE HOSPITALS FOR MENTAL DISEASES AND THE MANITOBA SCHOOL FOR MENTALLY DEFECTIVE PERSONS.

   The transfer of cases which require only custodial care would free 250 beds for mental cases and mental defectives—probably about 100 at Brandon, 100 in the Manitoba School for Mentally Defective Persons, and 50 at Selkirk.

2. THAT A PAVILION OR UNIT FOR INFIRMARY PATIENTS BE ESTABLISHED AT SELKIRK, BY REARRANGEMENT, RECONSTRUCTION, OR, IF NECESSARY, BY NEW BUILDINGS, WITH FACILITIES FOR ADEQUATE SEGREGATION OF TUBERCULOUS PATIENTS.

3. THAT MENTAL HYGIENE ACTIVITIES AT THE PSYCHOPATHIC HOSPITAL AND THE INSTITUTION AT BRANDON BE SUBSTANTIALLY INCREASED AND THAT SPECIFIC APPROPRIATIONS BE GRANTED FOR MENTAL HYGIENE.

4. THAT AT THE EARLIEST POSSIBLE MOMENT THE MANITOBA SCHOOL FOR MENTALLY DEFECTIVE PERSONS SEGREGATE ITS CASES IN ACCORDANCE WITH THEIR DEGREE OF MENTAL DEFECTIVENESS, SEPARATE CHILDREN FROM ADULTS, AND IN THE FUTURE ADMIT CHILDREN RATHER THAN ADULTS.

5. THAT TWO ADDITIONAL OCCUPATIONAL THERAPISTS BE EMPLOYED, ONE FOR THE HOSPITAL FOR MENTAL DISEASES AT SELKIRK AND ONE FOR THE PSYCHOPATHIC HOSPITAL IN WINNIPEG.

6. THAT THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE TAKE IMMEDIATE STEPS TO PROVIDE PASTEURIZED MILK FOR THE HOSPITAL FOR MENTAL DISEASES AT SELKIRK.

The recent acquisition of a physician trained in hospital administration to study hospitals and hospital administration in Manitoba provides a much needed service. The results of his survey may well form the basis for establishing minimum requirements for claiming the provincial per diem subsidy for public hospital care.

Generally speaking, the Province is conservative in its expenditures for preventive medicine and public health, and lavish in providing free hospital care. In balancing the merits of these policies, one should bear in mind two principles. First, that the investment of relatively small amounts for public health and preventive medicine will pay big dividends in reducing costs of medical care and hospitalization and in saving time now lost from school and work through unnecessary illness. Second, that while no person in need of such care and unable to procure it through his own resources should be refused, unnecessary hospitalization at public expense is an extravagance. At present it is altogether too easy for a person to obtain hospitalization without cost to himself. This is due primarily to unpardonable laxness on the part of the hospitals themselves, in admitting patients without any real effort to determine their financial status, and, in a lesser degree, to the readiness with which physicians recommend public hospital care. The present system unquestionably lends itself to abuse. The hospital notifies the municipality, or, if the patient lives in unorganized or disorganized territory, the Province, that a certain person who claims such and such residence has been admitted as a public case, and this transfers the responsibility for his care. If the patient is indeed a resident of the municipality or the territory notified, there isn't much that can be done but to pay the bill, although the municipality or province may try later to collect from the patient. It is not to be wondered at that hospitals would rather accept a patient as a public case, knowing that they will receive for his care $1.50 per diem from the municipality and 40 cents from the Province, than as a private case with considerable doubt of obtaining from him more than the initial payment. In some instances the municipality has been found to act in collusion with the patient. Here, the municipality assumed the responsibility for his care and the patient has re-imbursed the municipality afterward for the amount, at the paid rate of $1.50 per day. By this dishonest practice, the patient has avoided paying physicians' fees and the charges for x-ray treatments, operating room, et cetera. This system, and a definition of "emergency" which permits the hospitalization of almost any case under that pretext, unquestionably results in needless expense to the municipality and the province. An "emergency" is declared on presentation of a certificate "that it is unwise to delay admittance to the hospital until the authority of the health officer

or other authorized physician of the municipality is obtained". One might predict that public (municipal and provincial) payments for hospital care could be reduced by as much as 25 per cent if the technique of admitting were tightened up and the definition of "emergency" confined to its literal meaning. From the standpoint of the Provincial Department of Health and Public Welfare alone, this would mean an annual saving of about $150,000.00. Since hospital costs for public ward care vary markedly with differences in equipment and facilities, in size and in per cent of occupancy, it seems only right and proper that per diem rates for care should vary in accordance with the facilities available.

In order to prevent abuse of the privilege, and keep public hospitalization on a fair and equitable basis, it is recommended:

1. THAT ALL HOSPITALS RECEIVING CASES FOR WHICH THE MUNICIPALITY OR THE PROVINCE IS EXPECTED TO PAY, BE REQUIRED TO OBTAIN A WRITTEN STATEMENT FROM THE MUNICIPALITY OR PROVINCE ACCEPTING RESPONSIBILITY FOR PAYMENT AND CONFIRMING THE PATIENT'S DECLARATION OF HIS FINANCIAL CONDITION **BEFORE** THE ADMISSION; AND THAT, EXCEPT IN TRUE EMERGENCIES, FAILURE ON THE PART OF THE HOSPITAL TO OBTAIN THIS WRITTEN AUTHORIZATION SHALL ABSOLVE THE MUNICIPALITY OR PROVINCE FROM ALL RESPONSIBILITY TO PAY FOR THE PATIENT.

2. THAT THE PRESENT WORDING OF THE CLAUSE IN THE HOSPITAL AID ACT, WHICH PERMITS HOSPITALIZATION WTHOUT ANY AUTHORIZATION FROM THE MUNICIPALITY OR THE PROVINCE, BE CHANGED TO READ: "NO PATIENT SHALL BE ADMITTED TO HOSPITAL CARE AT PUBLIC EXPENSE WITHOUT THE WRITTEN AUTHORIZATION OF THE MUNICIPALITY OR PROVINCE UNLESS A PHYSICIAN CERTIFIES THAT THE PATIENT'S CONDITION IS SUCH THAT FAILURE TO HOSPITALIZE MAY SERIOUSLY ENDANGER HIS LIFE".

   In such an emergency, the hospital shall notify the municipality or province of the admission of the case within twenty-four hours of admission.

3. THAT ALL PERSONS IN THE PROVINCE BE PERMITTED TO USE THE OUTPATIENT FACILITIES OF THE WINNIPEG HOSPITALS PROVIDED SUCH

OUTPATIENT CARE IS RECOMMENDED BY THE MEDICAL HEALTH OFFICER OR OTHER AUTHORIZED PHYSICIAN AND IS FURTHER AUTHORIZED IN WRITING BY THE MUNICIPALITY IN WHICH THE PATIENT IS A RESIDENT, OR BY THE PROVINCE IF THE PATIENT RESIDES IN UNORGANIZED OR DISORGANIZED TERRITORY. SUCH AUTHORITY BY THE MUNICIPALITY SHOULD ALSO CERTIFY THAT THE PATIENT IS UNABLE TO PAY.

Authorization for such care should include the agreement to pay at the rate of 25 cents for each visit to the Outpatient Department plus the cost of special services, such as X-ray, Basal Metabolism, special laboratory tests, et cetera. Charges for such services should be listed by the hospital and sent to all medical health officers, physicians and municipal officials.

4-*a*. THAT THE LIEUTENANT-GOVERNOR-IN-COUNCIL APPOINT A HOSPITAL COMMISSION TO BE COMPOSED OF ONE REPRESENTATIVE FROM THE UNION OF MUNICIPALITIES, ONE FROM THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION, ONE FROM THE MANITOBA DENTAL ASSOCIATION, ONE FROM THE MANITOBA ASSOCIATION OF REGISTERED NURSES, ONE REPRESENTATIVE FROM THE PROVINCIAL GOVERNMENT, AND ONE HOSPITAL REPRESENTATIVE (PREFERABLY FROM OUTSIDE MANITOBA) TO BE APPOINTED BY THE CANADIAN HOSPITAL COUNCIL.

It is suggested that the hospital representative be appointed from outside the Province, because if chosen from Manitoba, his necessary association with a specific hospital in the Province might expose him to suspicion of bias.

b. THAT THE HOSPITAL COMMISSION MAKE A STUDY OF ALL HOSPITALS IN MANITOBA INCLUDING THE CONSIDERATION OF BED CAPACITY, BED OCCUPANCY, COSTS, MEDICAL, DENTAL AND NURSING FACILITIES, EDUCATIONAL FACILITIES, AND EQUIPMENT AND FACILITIES FOR PROVIDING VARIOUS SPECIAL TYPES OF CARE.

c. THAT, ON THE BASIS OF THIS STUDY, THE HOSPITAL COMMISSION GRADE ALL HOSPITALS IN THE PROVINCE AND RECOMMEND TO THE LIEUTENANT-GOVERNOR-IN-COUNCIL CERTAIN PER DIEM RATES FOR PUBLIC WARD CASES IN ACCORDANCE WITH THE GRADE OBTAINED BY EACH HOSPITAL.

For example, Grade A hospitals might be paid $2.00 per diem of care, Grade B hospitals $1.50, et cetera. Grades probably should include A through E, D being the grade which will receive the lowest per diem payment and E designated as "Not at present meeting minimum requirements for per diem payments by municipal or provincial governments."

In making the study and assigning grades to hospitals, the Hospital Commission should take into consideration the type and extent of available medical and nursing service. For example, Grade A hospitals would doubtless be approved for all types of service, Grade B perhaps for all types of care except certain special services. Grade C might be approved except for major surgery, and Grade D for only certain relatively simple types of care.

SECTION OF LOCAL HEALTH AND WELFARE SERVICE

The Section of Local Health and Welfare Service includes the Director and a consultation-advisory field staff.

Local Health Service. Full-time local health service is provided in but a small portion of the province. There are only four full-time health departments, which serve 273,256 people, or approximately 39.0 per cent of the total population of Manitoba, and they are: Winnipeg, St. James-St. Vital, St. Boniface and Brandon. Only one of these is outside the Winnipeg metropolitan area, and that is Brandon, the second largest city in the province. There is no full-time local health service in rural Manitoba.

The City of Winnipeg has a health department which, while still relatively weak, is under competent direction and gives promise of becoming a strong department in the near future. (For further details on Winnipeg, see the report on "Public Health Activities in Winnipeg—1941".)

No special study of the three departments outside of Winnipeg has been made. However, one of them, the St. James-St. Vital unit, achieved the National Honor Roll in the last annual Rural Health Conservation Contest conducted by the Canadian Public Health Association in cooperation with the American Public Health Association. The department at St. Boniface is in a developmental stage but has capable leadership and should become a strong unit. The health department at Brandon seems to present a less promising picture, principally because such a large proportion of the health officer's time is devoted to the medical care program.

All health officers in Manitoba must be physicians. There are approximately 170 part-time medical health officers, one for each of the municipalities not having full-time health service. The very fact that these medical men are health officers naturally makes them somewhat more sympathetic to the development of public health than might otherwise be the case. On the other hand, with a few notable exceptions, part-time health officers do very little public health work. The physician himself is not to be criticized for this because as a rule he is paid so very little as a part-time health officer, that he simply cannot afford to prepare himself for public health work or devote much time to it.

Of the 170 part-time health officers sixteen are full-time municipal doctors. The municipal doctors can and do carry on more public health functions than can be expected of the part-time health officer whose livelihood depends upon private practice. While, of the sixteen, only one has had specific public health training, nevertheless they conduct reasonably adequate antepartum, delivery and post-

partum services, immunize against smallpox and diphtheria, and give physical examinations to school children. Activities in the field of environmental sanitation are usually weak or not undertaken at all except to investigate complaints. The area now served by municipal doctors has an estimated population of 35,929, or about five per cent of the total population of the province.

The following tables, 4-A and 4-B, give the distribution of medical health officers and public health nurses with the populations served by them:

Table 4-A

MEDICAL HEALTH OFFICERS AND PUBLIC HEALTH NURSES IN MANITOBA

Area	Population	Population Served by		Number of		
		Health Officers	Public Health Nurses	Health Officers Full-time	Health Officers Part-time	Public Health Nurses
Four Full-time Health Units (All Urban)*a*	273,256	273,256	273,256	4	....	49*b*
Municipal Doctors (Organized Territory)	35,929	35,929	1,287	....	16	⅓
Other Organized Territory	339,446	339,446	88,210	....	153	12⅔*c*
City without Full-time Health Service	6,538	6,538	6,538	....	1	1
Total (Organized Area)*d*	655,169	655,169	369,291	4	170	63
Unorganized and Disorganized Territory*e*	44,831	....	28,600*f*	....	....	11
GRAND TOTAL	700,000	655,169	397,891	4	170	74*g*

a. Includes 3 cities and 2 municipalities (both municipalities are in the Winnipeg area)

b. Includes 5 nurses of the Provincial Health Department working in Winnipeg and suburbs.

c. Four of these nurses are in the Greater Winnipeg area.

d. Includes cities and organized municipalities with their towns and villages.

e. Whatever public health services this area receives are furnished by the Provincial Department of Health.

f. Estimated.

g. Includes 30 field nurses of the Provincial Health Department, of whom 9 are in the Winnipeg area. This does not include the four roving nurses who do not carry a generalized program.

Table 4-B

MEDICAL HEALTH OFFICERS AND PUBLIC HEALTH NURSES IN MANITOBA

Area	Per Cent of Each Area Served by			Per Cent of Manitoba's Total Population Served by			Population per		
	Health Officers		Public Health Nurses	Health Officers		Public Health Nurses	Health Officer		Public Health Nurse
	Full-time	Part time		Full-time	Part-time		Full time	Part-time	
Four Full-time Health Units (All Urban)	100.0	.....	100.0	39.0	.....	39.0	68,314	.....	5,577
Municipal Doctors (Organized Territory)	.....	100.0	3.6	.....	5.1	0.2	.....	2,246	3,861
Other Organized Territory	.....	100.0	26.0	.....	48.5	12.6	.....	2,218	6,962
City without Full-time Health Service	.....	100.0	100.0	.....	0.9	0.9	.....	6,538	6,538
Total (Organized Area)	41.7	58.3	56.4	39.0	54.5	52.7	.....	2,246	5,860
Unorganized and Disorganized Territory	.....	.....	63.7	.....	.....	4.1	.....	.....	2,600
GRAND TOTAL	39.0	54.6	56.8	39.0	54.5	56.8	See Note		

NOTE: While the total population of the province is not served by health officers or public health nurses, the relationship of total health officers and total public health nurses to total population is that of one health officer for each 4,023 population and one public health nurse for each 9,460 population.

Two general conclusions may be drawn from these figures:

(a) That there are not nearly as many full-time local health units as there should be:
(b) That the distribution of public health nurses is not such as to render the most effective service to the greatest number of people. Particularly is this true when one considers travel as an important item in supplying nursing services to sparsely settled areas.

Since two of the most important cardinal principles of effective province-wide public health programs are, first, the establishment of full-time local health units and, second, the distribution of personnel in such manner as to provide the most effective service for the most people, it would seem that something very definite is demanded to remedy the situation in Manitoba.

What can be done? One frequently hears the statement that Manitoba is a relatively poor province and that people can not afford to pay for local services. That this is not entirely true seems to be borne out by a review of per capita wealth. Per capita wealth in Manitoba, as given in "Proposed Equalized Assessment 1941-1942", ranges from a low of $147.00 to a high of $2,216.00, with a median of $707.00 and an average of $669.00. In the four areas supporting full-time health departments, including Winnipeg, per capita wealth ranges from a low of $266.00 to a high of $707.00. The median is $500.00 and the average $642.00. Although the low per capita wealth in areas having full-time service is somewhat higher than that for the province as a whole, the high is much less than that of the province and this is true also of the median and the average. It seems evident that full-time health departments have not been developed in Manitoba in proportion to local wealth and that the greater part of the Province could afford full-time local health service as well as the areas which have it, if not better.

The conclusion is justified that full-time local health departments have not been generally established simply because the people do not understand the need for such services and their value as an investment in health and happiness. The need for a province-wide health education program, designed to bring about such understanding is clearly evident.

The faults in the distribution of public health nurses are also clearly evident. Of the thirty field nurses of the Provincial Department of Health and Public Welfare (exclusive of the four roving nurses who do not render a generalized public health nursing service) nine, or 30 per cent, are working in the Winnipeg metropolitan area. The services given in Winnipeg should certainly be assumed by the Winnipeg City Health Department (see recommendation to this effect in the report on "Public Health Activities in Winnipeg—1941"), and the suburban areas should be able to afford and provide more of the services they require.

Aside from full-time local health departments where, of course, the nurse's services are far more profitable and effective than elsewhere, their next most effective use would seem to be in the municipal doctor areas, yet in the sixteen such territories, only one doctor commands any public health nursing service and he has about one-third of a nurse's time. In other words, only 3.6 per cent of the territory covered by municipal doctors has any nursing service. According to Table 4-A, page 96, altogether 13 2/3 of the 30 field nurses, or 45.5 per cent, are working in organized areas, including one city, and 11 or 36.7 per cent, are assigned to Unorganized or Disorganized territory. Sixteen nurses (five working in Greater Winnipeg and 11 in Unorganized or Disorganized territory), or 53.3 per cent, are being furnished without any additional cost to the areas they serve. Commencing immediately these sixteen nurses should be gradually withdrawn and moved to other districts, preferably full-time health departments and municipal doctor areas, where their activities are more acutely needed, where their efforts will be better rewarded and where the locality will finance a reasonable proportion of the cost of the service. The proportion of public health nurses to population varies from a high of one nurse to 6,962 people in the "Other Organized Territory" mentioned in Table 4-B, page 97 (that is, territory outside districts supplied with full-time health departments, municipal doctor areas and cities) to a low of one nurse to an estimated 2,600 people in Unorganized or Disorganized Territory.

While the Provincial Department of Health and Public Welfare is fully aware of the need for full-time local health departments, its program is not effectively designed for the achievement of this goal, since:

(*a*) There is no planned long range Province-wide health education program planned to develop an understanding of the need for full-time local health service.

(*b*) There is, in the Department, no Section or Bureau of Local Health Services.

(*c*) There is very little supervision of local full-time health departments, and practically no consultation-advisory field service.

(*d*) No steps have been taken to set up one well-developed rural health department as a demonstration of what can be done in providing adequate local health service, and as a training center for public health personnel.

(*e*) As has been said, the distribution of public health nurses is not conducive to the development of full-time local health departments. In fact in some areas it has doubtless acted as a deterrent, in that people probably feel that the nursing service fills all their requirements.

(*f*) No substantial effort has been made to increase the effectiveness of public health work among municipal doctors by offering them short courses in public health administration although municipal doctors are needed in additional rural areas. Most of these areas

are able to pay for benefits received and municipal doctors afford a real opportunity for implementing local health services.

Most encouraging is a recent inquiry addressed by the Department of Pensions and National Health in Ottawa to the Provincial Department of Health and Public Welfare, as to the strategic number of local full-time health units for Manitoba together with proposed budgets. It is hoped that the federal government is giving serious consideration to providing financial aid for this development. The need is most pressing throughout the Dominion and the failure to meet it constitutes the weakest link in Canada's public health program. Experience elsewhere, notably in the United States, indicates that public health effort will not achieve maximum results without substantial federal aid. Certain it is that the situation in the United States today is far superior to that which prevailed before the passage of the Social Security Act which provides, among other things, substantial financial aid to state and local health services.

In replying to the communication from the Department of Pensions and National Health, the Minister and Deputy Minister of the Manitoba Department of Health and Public Welfare recommended fifteen additional full-time health units for populations ranging from 7,500 to 29,500 and proposed budgets from $10,000.00 to $21,000.00. (Two of the units already in existence cover a portion of the proposed areas.) That the proposed health districts can afford to pay a reasonable portion of the cost is evidenced by a review of their per capita wealth. Per capita wealth in 14 of them, (one is as yet undesignated), ranges from a low of $250.00 to a high of $913.00. The median is $448.00 and the average $543.00. Locations for headquarters of the proposed units are: Portage la Prairie, Dauphin, Flin Flon, The Pas, Minnedosa, St. James, West Kildonan, East Kildonan, St. Boniface, Selkirk, Morris, St. Anne, Swan River and Brandon. (See list on pages 101-103.)

Many of these areas can and, because of their rural character, probably should employ municipal doctors. If this is done, the municipal doctor will be able to increase the effectiveness of the local public health program, and he should certainly become an integral part of the local health organization.

Proposed Health Unit Districts—Manitoba

No.	Name of District	Composition	Population	Per Capita Wealth	Annual Cost
1	Portage	City of Portage la Prairie; R.M. of Portage la Prairie....	12,000	$900.43	$ 11,000.00
2	Dauphin	Dauphin town, Gilbert Plains town; R. M. of Dauphin, Ochre River and Gilbert Plains	14,500	496.07	12,500.00
3	Flin Flon	Flin Flon town and district, Sherridon district	12,000	250.00	12,000.00
4	The Pas	The Pas town, Districts of Cranberry Portage & Hudson Bay Railway Line	7,500	321.00	10,000.00
5	Minnedosa	R.M. of Clanwilliam, Minto, Saskatchewan, Blanshard, Odanah, Strathclair, Harrison and adjacent townships in Unorganized Territory composing present Municipal Doctor districts of Elphinstone and Clanwilliam..	14,500	913.18	12,000.00
6	Suburban Area No. 1	Municipalities of Fort Garry, Tuxedo and St. James	16,500	378.85	13,000.00
7	Suburban Area No. 2	Brooklands, West Kildonan, Old Kildonan, West St. Paul municipalities	10,500	303.45	11,000.00
8	Suburban Area No. 3	Municipalities of East St. Paul; East Kildonan, and Transcona	14,500	270.99	13,000.00
9	Suburban Area No. 4	Municipalities of St. Vital, St. Boniface, and Ritchot	27,000	471.74	21,000.00
10	Selkirk	Municipalities of St. Andrews, St. Clements, and Gimli	15,000	419.28	13,500.00
11	Morris	Town of Morris; R.M. of Morris, Montcalm, and DeSalaberry	11,000	889.44	11,000.00
12	St. Anne	R.M. of St. Anne, Tache, La Broquerie, and Hanover	14,000	335.89	13,000.00
13	Swan River	Town of Swan River; R.M. of Swan River, Minitonas; adjacent Unorganized Territory	12,000	621.26	12,500.00
14	Brandon	City of Brandon; R.M. of Cornwallis, Daly, Elton, Oakland; Town of Rivers, and Village of Wawanesa	22,000	732.48	16,500.00
15	(Unnamed)		12,000		12,000.00
	TOTAL		215,000	$542.70	$194,000.00[1]

R.M. means Rural Municipality.

[1] Approximately 90.2 cents per capita.

In addition to the fourteen proposed health units and the sixteen areas at present employing a municipal doctor, it seems probable that there are at least thirty-five municipalities which could and, because of their rural character and the difficulty of obtaining adequate local medical services, should employ municipal doctors. Four of these municipalities are already engaged in negotiations to that end. If and as this is done, it would seem feasible and desirable to unite these in health districts each comprising from four to seven municipal doctor areas, with a minimum staff of a qualified full-time health officer, two or more public health nurses, a sanitarian, and a secretary-clerk. A list of these proposed additional health districts follows:

Proposed Additional Health Districts

District	Municipalities	Population	Per Capita Wealth	Estimated Annual Cost
1	Shell River[1]	3,406	$ 550.79	
	Hillsburg	1,737	305.70	
	Grandview	3,442	575.25	
	Shellmouth	1,844	710.95	
	Boulton	1,786	439.53	
	Silver Creek[1]	1,898	917.28	
	Rossburn[1]	3,725	497.99	
Total District No. 1		17,838	$ 565.03	$ 16,100.00
2	Ellice	1,476	$ 458.67	
	Birtle	3,133	996.17	
	Archie	1,502	856.85	
	Miniota	2,363	1,146.00	
Total District No. 2		8,474	$ 919.64	$ 7,650.00
3	McCreary	2,488	$ 303.05	
	Glenella	1,726	281.00	
	Westbourne	3,566	623.39	
	Langford	3,381	930.20	
	North Cypress	3,389	928.89	
Total District No. 3		14,550	$ 670.45	$ 13,125.00
4	Pipestone	2,936	$1,098.43	
	Sifton	1,921	778.76	
	Whitehead	1,630	1,303.06	
	Albert	1,271	883.55	
	Cameron	1,971	1,071.03	
	Whitewater[1]	1,729	1,467.90	
Total District No. 4		11,458	$1,101.15	$ 10,340.00

Proposed Additional Health Districts (Cont'd)

District	Municipalities	Population	Per Capita Wealth	Estimated Annual Cost
5	Victoria	1,984	$ 835.18	
	South Norfolk	3,276	760.07	
	Lorne	5,241	666.86	
	Argyle[1]	2,687	1,067.73	
	Strathcona	2,157	797.87	
	Riverside[1]	1,709	1,100.64	
Total District No. 5		17,054	$ 827.55	$ 15,400.00
6	Edward[1]	1,287	$ 918.41	
	Arthur	1,841	970.67	
	Brenda[2]	2,137	1,090.78	
	Morton	3,094	994.50	
	Turtle Mountain	3,761	863.86	
Total District No. 6		12,120	$ 959.24	$ 10,900.00
7	Roblin[1]	2,058	$1,167.15	
	Louise	3,285	1,203.35	
	Pembina[2]	4,709	837.33	
	Thompson	2,136	1,046.81	
	Roland	2,309	1,267.21	
	Rhineland	9,532	678.03	
	Franklin	5,203	804.15	
Total District No. 7		29,232	$ 893.10	$ 26,900.00
8	Woodlands[2]	2,293	$ 681.20	
	Cartier[1]	3,276	763.43	
	Grey[1]	3,913	707.90	
	Macdonald[2]	3,579	1,596.53	
Total District No. 8		13,061	$ 960.65	$ 11,800.00
GRAND TOTAL (8 District Health Units)		123,787	$ 845.30	$112,215.00 (A cost of about 90 6 cents per capita)

[1] Already have a municipal doctor (9).
[2] Negotiating for a municipal doctor(4).

To bring about a more rapid expansion of full-time local health service, which is the paramount need of Manitoba, and to assist local health departments to make the most effective use of their facilities, it is recommended:

1. THAT THERE BE ESTABLISHED IN THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE A SECTION OF LOCAL HEALTH AND WELFARE SERVICE WITH A PHYSICIAN, ESPE-

CIALLY TRAINED AND EXPERIENCED IN PUBLIC HEALTH ADMINISTRATION, AS ITS DIRECTOR.

The Director of Local Health and Welfare Service, with the advice and counsel of the Minister and Deputy Minister, the Directors of Divisions, and his own field staff, should plan the organization and basic program for local health departments and assist in obtaining trained personnel for them. Local health service is the most important single service of the entire public health program and the section devoted to it should therefore have its personnel most carefully selected.

2. THAT THE ENTIRE DEPARTMENT OF HEALTH AND PUBLIC WELFARE DEVOTE ITS MAJOR EFFORTS TOWARD THE ESTABLISHMENT OF FULL-TIME LOCAL HEALTH DEPARTMENTS.

3. THAT THE PERSONNEL OF THE SECTION OF LOCAL HEALTH AND WELFARE SERVICE IN ADDITION TO THE DIRECTOR, CONSIST OF A DIRECTOR OF FIELD STAFF, WHO SHOULD BE A PHYSICIAN TRAINED AND EXPERIENCED IN LOCAL HEALTH SERVICES, AND A FIELD CONSULTATION-ADVISORY-SUPERVISORY STAFF TO AID FULL-TIME LOCAL HEALTH DEPARTMENTS AND TO ASSIST IN THE DEVELOPMENT OF SUCH DEPARTMENTS.

The field staff should if possible be composed of personnel loaned from other bureaus and divisions of the Department. It should consist of a well-trained physician as director, public health nurses with special training and experience in supervising a generalized public health nursing program, qualified social workers, capable of supervising generalized welfare activities, sanitarians with expert knowledge of the theory and practice of the various aspects of environmental sanitation, and one or more efficient public health statistical clerks. If necessary, new personnel should be employed for these important technical positions. The members of this field staff should be attached to their respective bureaus or divisions and be responsible to their respective bureau or division directors for policies and techniques. However, they should be assigned to the Director of Local Health Services and be responsible to him for field assignments and day to day administration.

The field staff should have no routine central office duties and should be in the field constantly except for periodic conferences with the Director of the Section of Local Health Service and with bureau and divisional directors. The Director must correlate and balance the activities of all bureaus and divisions of the Department before they are translated into the local program, if health departments are to develop balanced programs geared to local needs.

The addition of field personnel to the Section of Local Health Services does not remove from bureau and divisional directors the responsibility for personal field visits. On the contrary, the findings of the field personnel will assist the directors to plan their own activities more profitably and constructively. When plans of bureaus or divisional directors involve possible changes of established

policies, such plans should be discussed with the Director of Local Health Services, and later with the Deputy Minister.

4. THAT, AS FULL-TIME LOCAL HEALTH DEPARTMENTS ARE ORGANIZED, THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE DISCONTINUE ITS DIRECT SERVICES TO LOCAL AREAS, EXCEPT FOR EMERGENCY AND HIGHLY TECHNICAL SERVICES.

   This recommendation is made because supplying direct services from the Central Office is costly and relatively ineffective and in many instances acts as a deterrent to the development of adequate local health services.

5. THAT, AS A COROLLARY TO THE ABOVE, THE AGENCIES ADMINISTERING THE PROVINCIAL PUBLIC HEALTH PROGRAM STATE FRANKLY THAT IT IS TOO EXPENSIVE AND INEFFICIENT TO SUPPLY SERVICES FROM THE PROVINCE TO SPARSELY SETTLED UNORGANIZED AND DISORGANIZED AREAS EXCEPT FOR EMERGENCY AND HIGHLY TECHNICAL SERVICES.

   Persons who live in very sparsely settled areas, unable to conduct their own governmental functions, pay far less in taxes than those in populous areas, and therefore must expect the minimum in service from the Provincial Government and other provincial agencies.

6. THAT THE DIRECTORS OF ALL BUREAUS AND DIVISIONS AND ALL STAFF MEMBERS OF THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE BE REQUIRED TO DEVELOP AND PROJECT THEIR RESPECTIVE PROGRAMS THROUGH THE SECTION OF LOCAL HEALTH AND WELFARE SERVICES.

A service manual, including a very brief analysis of laws, a discussion of general public health and welfare policies, a description of the various phases of public health and welfare which should be included in a balanced program, and a glossary of available services, such as general medical, dental, hospital and nursing care, welfare and voluntary agency services, tuberculosis clinics, institutions for the tuberculous, et cetera, would prove invaluable to all health and welfare personnel. Such a service manual might well be prepared by a Committee consisting of the Assistant Deputy Ministers in charge of Health and Welfare, the Director of the Section of Local Health Services, and the Director of Health Education.

7. THAT A SERVICE MANUAL BE PREPARED TO INCLUDE A BRIEF ANALYSIS OF HEALTH AND

WELFARE LAWS, A DISCUSSION OF GENERAL PUBLIC HEALTH AND WELFARE POLICIES, A DESCRIPTION OF THE VARIOUS PHASES OF PUBLIC HEALTH AND WELFARE WHICH SHOULD BE INCLUDED IN A BALANCED PROGRAM, AND A GLOSSARY OF AVAILABLE SERVICES.

In the preparation of such a manual the Committee should make use of personnel in local areas including health officers, welfare workers, nurses, sanitarians and clerks.

8. THAT ONE ESPECIALLY WELL PLANNED AND WELL STAFFED FULL-TIME HEALTH AND WELFARE UNIT, OF FROM FOUR TO SEVEN MUNICIPALITIES, BE ESTABLISHED AS A DEMONSTRATION OF WHAT CAN BE DONE IN PROVIDING ADEQUATE LOCAL HEALTH AND WELFARE SERVICES, AND BE USED AS A TRAINING CENTRE FOR PUBLIC HEALTH AND WELFARE PERSONNEL.

9. THAT, AS FULL-TIME LOCAL HEALTH DEPARTMENTS ARE ESTABLISHED, CONSIDERATION BE GIVEN TO COMBINING IN SUCH DEPARTMENTS HEALTH, WELFARE AND PUBLIC MEDICAL AND DENTAL CARE PROGRAMS.

To assist further in the development of more effective local health service, see the Section on Public Health Nursing, recommendations 2-*a*, *b*, *c*, and 3.

MUNICIPAL DOCTORS

Municipal doctors, the areas they now serve and the additional areas which might profitably employ them, have been discussed very briefly in several sections of this report, notably in "Principal Strength and Weakness of Public Health administration in Manitoba", "Major Recommendations" (see Recommendations 19-21), "Public Health Nursing", and "Local Health Service".

The municipal doctor plan, in spite of some weaknesses, seems to fill a very definite and important need for outlying rural areas in Manitoba and doubtless should be encouraged in additional territories. Without some such plan many rural districts would be entirely without local medical service.

The municipal doctor plan is one in which a municipality, a part of a municipality, or parts of several municipalities contract with a physician at a fixed annual salary to render medical service to all the people of the area regardless of their ability to pay. The Manitoba legislation permits any municipality to prepare a by-law

in respect to engaging a municipal doctor. After it has been given its first reading in Council, the by-law, together with a copy of the proposed contract, must be submitted to the Department of Health and Public Welfare for the Minister's approval. When approved, the plan is submitted to vote by the resident ratepayers (taxpayers) and declared carried if three-fifths of the votes are in favor. It is financed by a direct tax levied for this specific purpose. When a municipal doctor is appointed, he automatically becomes the health officer of the area.

The municipal doctor plan originated in 1920. In early days the contracts varied considerably. Today, they are fairly uniform except as to salary and the area to be served. By and large, they prescribe that the physician shall supply general medical care including minor surgery to all residents of the area without charge. They also provide that as health officer, the physician shall perform certain functions, principally vaccination against smallpox, immunization against diphtheria, physical examination of school children, and investigation of sanitary conditions. Ordinarily, the municipal doctor is permitted to make a reasonable charge for drugs and medical supplies, unless the contract includes these, and for x-ray or major surgery if he undertakes it. As a protection against the neurotic who is always wanting a doctor, the physician is permitted to make a charge of $2.00 for the initial call in any given illness. However, in rural areas this provision is seldom invoked. The physician is permitted to charge $1.00 for extracting a tooth.

In its present form the municipal doctor scheme dates from 1935. Today there are sixteen municipal doctors, all in entirely rural areas. Three municipal doctors had taken their diplomas in Public Health but unfortunately one of these has gone into military service and one to the Provincial Department. There are many other rural municipalities which could afford municipal doctors, and in which the need is just as great as in the areas which have them. Why these have not adopted the plan is a question. It is reasonable to suspect that two factors are involved, first, the lack of an effective educational program, and second, the innate conservatism of the population.

There is ample evidence that the municipal doctor plan is liked by both physicians and citizens of the area. Interviews with municipal doctors elicit such statements as: "I practised medicine in rural Manitoba for years and had a good practice but couldn't collect enough to make a living. Now, as municipal doctor, I practise knowing that regardless of collections I can maintain a home and educate my children." And from the citizen of the area, one hears such statements as: "The doctor gives us good service and we can see him now without thinking of whether we can afford to pay him."

The organization of the Provincial Department of Health and Public Welfare, and the municipal doctor plan, seem to be funda-

mentally sound for entirely rural areas. One should emphasize "rural areas" in this statement because the set-up would not seem to be desirable or feasible in urban areas.

The weaknesses of the municipal doctor plan as it operates at present are:

1. The Provincial Department of Health and Public Welfare has no means of supervising adequately the plan.
2. While contracts between municipality and physician are more uniform now than in former years, they need further strengthening and improving, particularly in the definition of the physician's duties and the protection of his rights.
3. There is no uniform or satisfactory plan for major surgery.
4. The fact that the municipal doctor is permitted to charge $1.00 for extracting a tooth indicates clearly the need for planned dental service.
5. The public health services performed by the physician in his capacity as health officer are limited, and likely to be weak particularly in the field of environmental sanitation. The municipal doctor should undergo special public health training if he is to serve as health officer.
6. At present it is possible for one physician to underbid another and thus accept as municipal doctor a salary below the fixed minimum.
7. The area served by the municipal doctor is too small in terms of population and financial resources to afford by itself an adequate public health service.

At present the sixteen municipal doctors serve an estimated population of 35,929, representing 5.1 per cent of the total population*, or 9.1 per cent of the total rural population**. It has been estimated that thirty-five additional rural municipalities need and can afford the services of municipal doctors. Four of these are already negotiating for municipal doctors. If and when this arrangement goes into effect, these areas might profitably be combined into perhaps eight District Health Units as suggested in the section on Local Health and Welfare Service.

In order to encourage further development of the municipal doctor plan, and to correct certain weaknesses of the present system, it is recommended:

1. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE IN COOPERATION WITH THE PROPOSED HEALTH EDUCATION COUNCIL, DEVELOP AN EDUCATIONAL PROGRAM TO ENCOURAGE RURAL AREAS, WHICH NEED AND CAN AFFORD SUCH SERVICE, TO EMPLOY MUNICIPAL DOCTORS.

*Based on a total population of 700,000.
**Based on total rural population of 393,960.

2. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE PROVIDE AN ADEQUATE SUPERVISORY, CONSULTATION-ADVISORY FIELD SERVICE FOR MUNICIPAL DOCTORS AND FOR MUNICIPALITIES EMPLOYING SUCH DOCTORS.

3. THAT EACH MUNICIPALITY OR AREA EMPLOYING A MUNICIPAL DOCTOR UNDERTAKE TO PROVIDE AND FINANCE NECESSARY MEDICAL SERVICES NOT INCLUDED IN THE CONTRACT WITH THE MUNICIPAL DOCTOR.

4. THAT MUNICIPALITIES OR AREAS EMPLOYING MUNICIPAL DOCTORS ALSO FORMULATE A PLAN FOR THE PROVISION OF DENTAL CARE.

5. THAT THE PROVINCIAL DEPARTMENT OF HEALTH AND PUBLIC WELFARE PROVIDE SHORT COURSES ON HEALTH PROTECTION AND HEALTH PROMOTION SERVICES FOR MUNICIPAL DOCTORS. THESE COURSES SHOULD PARTICULARLY EMPHASIZE ENVIRONMENTAL SANITATION AND INFANT AND PRESCHOOL HYGIENE.

Such courses should be given on a regional basis, each covering a period of four to six weeks. The location and schedule should permit the doctors to spend part of each day in their offices.

6. THAT THE CONTRACTS BETWEEN MUNICIPALITIES AND MUNICIPAL DOCTORS AND THE REGULATIONS BEARING ON SUCH CONTRACTS BE STILL FURTHER STANDARDIZED TO INCLUDE, IN ADDITION TO THEIR PRESENT PROVISIONS FOR VACATION, LEAVES OF ABSENCE, ET CETERA:

(*a*) THAT NO MUNICIPALITY OR AREA SHALL EMPLOY A MUNICIPAL DOCTOR FOR LESS THAN THE MINIMUM SALARY STIPULATED FOR SUCH POSITION;

(*b*) THAT THE MUNICIPAL DOCTOR SHALL HAVE CERTAIN SPECIFIED OFFICE HOURS AND NOT BE EXPECTED TO BE ON DUTY AT OTHER TIMES EXCEPT FOR EMERGENCIES;

(*c*) THAT ALL CONTRACTS PROVIDE A CLEAR-CUT AND CONSISTENT DEFINITION OF THE DUTIES OF THE MUNICIPAL DOCTOR, PARTICULARLY AS REGARDS "MINOR SURGERY";

(*d*) THAT CONTRACTS INCLUDE AN AGREEMENT ON THE PART OF THE MUNICIPALITY TO PROVIDE AND FINANCE NECESSARY MEDICAL SERVICES NOT COVERED IN THE CONTRACT;

(*e*) THAT CONTRACTS PROVIDE THAT IN CASE OF ANY DISPUTE BETWEEN THE MUNICIPAL DOCTOR AND ANY RESIDENT OF THE AREA, OR BETWEEN THE DOCTOR AND THE MUNICIPALITY, SUCH DISPUTE MAY BE REFERRED TO A COMMITTEE COMPOSED OF THE DEPUTY MINISTER OF HEALTH AND PUBLIC WELFARE OR HIS REPRESENTATIVE, A REPRESENTATIVE OF THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION, AND A REPRESENTATIVE OF THE MUNICIPAL GOVERNMENT.

This committee should hear and adjudicate such disputes, and its decision should be binding on all parties.

SECTION OF PUBLIC WELFARE

The Section of Public Welfare consists of the Bureaus of Child Welfare, Social Assistance in Unorganized Territory, and Grants to Charitable Institutions. (See Organization Chart, page 26A.)

Historical. The Social Welfare Congress of Manitoba in 1916 passed a resolution stressing the need for a provincial department of public welfare. The Lieutenant-Governor-in-Council in 1917 appointed a Welfare Commission which recommended:

(*a*) The creation of a department of public welfare to include child welfare, public health, relief and correction, and mothers' allowances;

(*b*) The establishment of a welfare supervision board, and

(*c*) The consolidation of provincial child welfare legislation to be administered by one department of government.

An act creating a welfare supervision board was enacted in 1921. An act creating a department of public welfare with a division of child welfare was passed in 1922. Child welfare legislation was consolidated in 1924. The act became known as the Child Welfare Act, and has since been amended and consolidated into the Revised Statutes of Manitoba, 1940, chapter 32. A Division of Child Welfare was created under the Minister of Public Welfare who at that time was also the Minister of Education. The Mothers' Allowance Act, the Infants' Act, the Illegitimate Act, and sections of the Humane Society Act were repealed and their content embodied in the Child Welfare Act.

The Health and Public Welfare Act of 1928 united health and the major portion of provincial welfare activities under one department of government with a minister in charge. This is the present Department of Health and Public Welfare. There are still several public welfare activities administered by other provincial departments which logically belong in the Department of Health and Public Welfare. Among these are Old Age Pensions, and Pensions for the Blind.

Unemployment Relief. Rural rehabilitation and unemployment relief are administered through the Department of Public Works. Previous to 1914 all unemployment relief was a responsibility of the municipality. With the outbreak of war in 1914, many persons were thrown out of work. Also, many of the soldiers returning from the war in 1920 and 1921 found difficulty in re-establishing themselves. It became necessary for the province to assist with unemployment relief in 1914 and each year since 1919 it has done so. The Dominion government has assisted with unemployment relief every year from 1920 until March 31, 1941, with the exception of part of 1924 and 1925.

The present trend in the solution of unemployment is through public work projects with insurance to assist in time of emergency. Therefore, for the time being, it would seem advisable to leave unemployment relief in the Department of Public Works.

Field investigation of cases in unorganized territory requesting unemployment or other types of relief should be made by trained workers. Generalized social service workers from the Department of Health and Public Welfare should be available for this purpose irrespective of which department makes the grant.

Welfare Supervision Board. The Welfare Supervision Board consists of nine members appointed by the Lieutenant-Governor-in-Council. It is a nonpolitical body and the members receive no remuneration. They are selected, for the most part, on the basis of personal character and experience, serving in rotation for a term of three years with the option of reappointment. There is a paid part-time secretary.

The Welfare Supervision Board was created before the establishment of the Department of Health and Public Welfare. Its functions at that time were to make studies, on request, and to give advice concerning public welfare problems to any department of government. As public welfare activities have become centralized in the Department of Health and Public Welfare, the board has become more closely related to this than to other departments of the government, and its responsibilities have changed somewhat. Many studies which formerly would have been made by the Welfare Supervision Board are now made by the Winnipeg Council of Social Agencies. The specific duties of the board as outlined by the Act are:

(*a*) To inspect and report upon all activities, agencies, organizations, or institutions having for their object the social welfare or care of men, women, and children in Manitoba;

(*b*) To investigate from time to time and, if approved, to endorse and recommend to the Lieutenant-Governor-in-Council every welfare institution or agency carrying on its work in Manitoba which is not wholly under the control of the Government of Manitoba;

(*c*) To make recommendations to the Lieutenant-Governor-in-Council in respect to the basis of amount of any payment in support of or grant to any benevolent institution or organization whether wholly or in part under private control;

(*d*) To recommend to the Lieutenant-Governor-in-Council regulations respecting welfare institutions or organizations, and governing the soliciting of alms, food, clothing, moneys and contributions of any kind for benevolent purposes in Manitoba;

(*e*) To carry on research work in respect to any of the activities, organizations or institutions over which the board has supervision.

As now organized, the chief function of the Welfare Supervision Board should be to act as an advisory body to the Department of Health and Public Welfare. Its relation to welfare should parallel the relation of the Board of Health to health. However, there is at present no organic relation between the Welfare Supervision Board and the Department of Health and Public Welfare. Such a relation could be established by making the Minister of Health and Public Welfare an ex officio member and the Deputy Minister the executive member of the board.

General Administration. The Deputy Minister is in direct charge of departmental public welfare activities and since 1932 has been, by arrangement, Director of Child Welfare. Because of his many duties, it is impossible for the Deputy Minister to administer public welfare activities in detail. He must delegate such work to assistants. He should have on his staff a person suited by personality, training and experience to direct, under his supervision, the entire public welfare program.

The health and public welfare activities of the Department of Health and Public Welfare are administered jointly from the general office. Public welfare's share of general administrative expenses is estimated at approximately $12,386.00, of which $6,786.00 is for salaries and $5,600.00 for the maintenance of females in refuge homes.

The welfare branch is organized in three divisions: Child Welfare, Social Assistance in Unorganized Territory, and Grants to Charitable Institutions. As other public welfare activities become centralized in the Department of Health and Public Welfare, it may be found necessary to establish other divisions.

SOCIAL ASSISTANCE IN UNORGANIZED TERRITORY

The staff of the Division of Social Assistance in Unorganized Territory consists of the Director, one inspector and four clerks. The budget is $104,040.00, of which $6,540.00 is for salaries, $1,345.00 for supplies and equipment, $1,155.00 for travel, and $95,000.00 for direct financial aid.

The function of this Division is to extend assistance to bona fide residents of Unorganized Territory in Manitoba who are unable to care for themselves or their dependents because of situations involving:

(*a*) Illness of the breadwinner.

(*b*) Widows pending determination of eligibility for mothers' allowances.

(*c*) Deserted mothers.

(*d*) The aged under seventy.

(*e*) Aged persons over seventy but not eligible for Old Age Pension.

(*f*) Certain other factors.

The function of this Division is largely social service. For the calendar year 1940 relief was given to 612 cases having 1,564 dependents or a total of 2,176 individuals. Cases come to the attention of the Department in various ways. Many persons apply directly; others are referred by a doctor, nurse, neighbor, or some other interested person. Only one member of the staff is available at any given time for field work, including the investigation of claims for assistance, and the major part of these investigations are done by seven tax collectors employed by the Department of Education. Their field expenses are paid by the Department of Health and Public Welfare. Such persons are usually not trained in social work and may lack the time or the understanding required for assisting in the social adjustments which frequently lead to rehabilitation. There is always the danger of giving help year after year, when intelligent planning by a person of experience might eliminate the cause of dependency, aside from the fact that the counsel of such a person is, in itself, as valuable as material aid.

It is important that the Division be directed by a suitably qualified person. As case investigators should be properly trained, it would seem desirable to employ for this service social workers and public health nurses on the staff of the Department, who already cover the Unorganized Territory in which social assistance is given, rather than to depend upon untrained persons attached to other departments.

GRANTS TO CHARITABLE INSTITUTIONS

Grants to charitable institutions, exclusive of hospitals, are made by the Department of Health and Public Welfare upon the recommendation of the Welfare Supervision Board. The staff of the Division consists of one part-time person who is secretary to the Welfare Supervision Board.

The budget estimated for the year ending April 30, 1942, is $31,445.00 of which $300.00 is for salary, $188.00 for supplies, $162.00 for travel, and $30,795.00 for direct financial aid. The following grants to charitable institutions were recommended for the present fiscal year:

Children's Aid Society of St. Adelard	$ 675.00
Children's Aid Society of Winnipeg	2,700.00
Children's Aid Society of Dauphin	1,800.00
Children's Aid Society of Western Manitoba	1,800.00
Children's Aid Society of Central Manitoba	1,800.00
Children's Home of Winnipeg	3,600.00
Knowles' Home for Boys	1,670.00
Asile Ritchot Infants' Home, St. Norbert	1,150.00
St. Joseph's Vocational School	1,760.00
Jewish Orphanage and Children's Aid Society of Western Canada	500.00
St. Agnes Priory—West Kildonan	900.00
St. Benedict's Orphanage	360.00
Old Folks' Home—Winkler	50.00
Old Folks' Home—Gimli	50.00
Canadian National Institute for the Blind	6,300.00
Margaret Scott Nursing Home	675.00
Salvation Army—Winnipeg	900.00
Victorian Order of Nurses	585.00
Last Post Fund, Manitoba Division	360.00
Canadian Foundation for Preventive Dentistry, Manitoba Division	500.00
Canadian Red Cross Society	2,160.00
Sir Hugh John Macdonald Memorial Hostel	500.00
	$30,795.00

Field investigations are made by Board members. An evaluation of charitable institutions with regard to physical plant and actual services by a committee of one or more persons trained in this field would be useful as a basis for making grants. The staff of the Department of Health and Public Welfare should be available to the Welfare Supervision Board for this purpose, and it might then be ascertained whether a given institution was fulfilling a useful place in the province and giving the maximum return for the funds expended.

Incorporation of Private Welfare Agencies. Groups of persons or private agencies desiring to be incorporated for welfare purposes should make application to the Department of Health and Public Welfare. In communities having a Council of Social Agencies the request should first be made to the Council, which then refers it to the Department. The Department should determine, among other things, the intended purpose of the agency, whether it will contribute anything of value, whether it will duplicate services already provided, and whether it has the staff and financial resources to accomplish its objectives. After the investigation has been made, the findings with recommendations should be presented to the Welfare Supervision Board for action.

Child Welfare Board. The Child Welfare Board is appointed under Part I, Section 7 (1) of the Child Welfare Act. The Lieutenant-Governor-in-Council appoints the board which according to the Act shall consist of not less than five or more than seven members, one of whom shall be of the Roman Catholic faith. Although this is not required by law, labor is usually represented. The members of the Board meet monthly and serve without remuneration. The supervisor of the Mothers' Allowance Section acts as secretary to the Board.

Originally the principal function of the Board was to serve in an advisory capacity in administering the Child Welfare Act. Since 1932 the Board has been requested to assume certain additional functions. The Board now passes upon the eligibility of every mother who applies for aid, and determines the amount of the grant to which she is entitled under the act and regulations. Complaints concerning the administration of the Child Welfare Act are referred to the Board.

The advisory, supervisory and administrative functions of extra-departmental groups over the child welfare activities of the Department should be clarified. The statute gives the Child Welfare Board and the Welfare Supervision Board wide and overlapping powers in the field of child welfare, yet no organic relation exists between the two bodies. It would seem advisable that the Child Welfare Board be made the standing committee on child welfare of the Welfare Supervision Board.

The Child Welfare Board also lacks organic relation to the Department of Health and Public Welfare. It should include in its membership a departmental staff member familiar with general administrative policies and specific welfare activities. This will facilitate better interdepartmental relationships, and closer coordination of effort.

The Child Welfare Board should be an advisory, judiciary, policy-forming but not executive body. Rules and regulations formulated under the Act should be approved by the Board but the Act should be administered by qualified paid members of the staff.

The members of the Child Welfare Board are appointed for an indefinite period, and do not serve in rotation. This may limit the value of the organization. There is a danger that members may continue to serve after they have passed the age of maximum usefulness, and the Board is denied the stimulus introduced by new members, also with different points of view and new ideas. A rotating Board also insures that a larger number of leading citizens of the province is given opportunity to become familiar with the problems, needs and activities in the field of child welfare.

Children's Aid Societies. As provided in Part VII, Sections 83, 84 and 85 of the Child Welfare Act, any twelve or more persons over the age of twenty-one years, who desire to associate themselves for the purpose of carrying on work for the welfare or protection of children may make application for incorporation and upon the Minister giving his approval, shall be known as a Child Welfare Association or, if the persons so desire, as a Children's Aid Society. Such societies take an active part in protecting and providing for children in accordance with the health and welfare legislation of Manitoba. At present there are six Children's Aid Societies in Manitoba:

Children's Aid Society of St. Adelard.
Children's Aid Society of Winnipeg.
Children's Aid Society of Dauphin.
Children's Aid Society of Western Manitoba.
Children's Aid Society of Central Manitoba.
Jewish Orphanage and Children's Aid Society of Western Canada.

The province grants funds to the Children's Aid Societies through the Department's Division of Grants to Charitable Institutions. Children's Aid Societies also receive voluntary contributions. They have paid workers and take an active part in administering Part IV of the Child Welfare Act which has to do with "Neglected Children", and Part V which concerns "Children of Unmarried Mothers".

For the fiscal year ending April 30, 1941, approximately 975 children were declared neglected by the courts. Of this number 697 were wards of the Children's Aid Societies and 278 of the Director of Child Welfare. The Children's Aid Societies have a broader program than the activities outlined under Parts IV and V of the Child Welfare Act. They do family case work and are interested in all aspects of child welfare. They use voluntary contributions to finance the broader aspects of the program.

Child Welfare Committees. The Child Welfare Act makes provision for the appointment of two different child welfare committees. Under authority of Part III, Section 18 (2), the Board may appoint in any municipality or district in unorganized territory, a committee of not less than three members to assist the Director in the investigation and supervision of cases of bereaved and dependent children residing therein, and the committee shall report to the Directors. Members of a committee shall hold office for one year or until their successors are appointed unless otherwise specified by the Board at the time of their appointment. Under authority of Part VII, Section 90, when the community does not have a Children's Aid Society, the Director may require the Secretary-treasurer of each municipality to submit to him the names of ten responsible

persons of the municipality, and he may select from these not less than three nor more than five persons to be known as the Child Welfare Committee. The Director may grant the committee such powers and impose such duties as he deems necessary for the welfare and protection of the children of the municipality.

To simplify administration it would seem advisable to have but one child welfare committee in a community, to which all pertinent problems, including, of course, questions bearing on child health, could be referred.

Royal Commission of 1928. A Royal Commission was appointed in 1928 to inquire into the administration of the Child Welfare Division. A study and evaluation of child welfare legislation, administration, policies and resources were made. The report is an interesting document and has been a factor of considerable importance in the reorganization of the Division.

Child Welfare Division. The staff of the Child Welfare Division consists of a director who, at present, is the Deputy Minister, an assistant director, three social work supervisors, 13 social work visitors, two inspectresses and 16 clerks, a total of thirty-five persons. The estimated budget for the fiscal year ending April 30, 1942, is $513,894.00. Of this $41,419.00 is for salaries, $6,712.00 for renewals, $5,763.00 for travel and $460,000.00 for direct financial aid.

It is the responsibility of this Division to administer the provisions of the Welfare Act of 1924 and its amendments. When passed, this was considered by the Royal Commission to be the most comprehensive act of its kind on the statute books of any Canadian Province. At that time the provisions made for the administration of the Act were far from commensurate in terms of funds and staff, with the far-reaching responsibilities placed upon the province. After the report of the Royal Commission considerable revision was made although much yet remains to be accomplished in this field.

Since 1932, the Deputy Minister of Health and Public Welfare has been Director of Child Welfare by arrangement. Because of the magnitude of his responsibilities, the Deputy Minister should be relieved of this duty, and the Assistant Deputy Minister, in charge of welfare, made Director as recommended under plan of organization, page 26A.

Upon recommendation of the Royal Commission, the activities of the Child Welfare Division were reorganized in three sections with a supervisor in charge of each. At first social workers were attached to each section, but this was found to be unpractical, wasteful and confusing, and now throughout the Province, except in Greater Winnipeg, the field work, covering Mothers' Allowance, Child Care and Protection, and Legal Supervision, is generalized.

Mothers' Allowance. This section jointly with the Child Welfare Board, administers allowances to bereaved and dependent children whose fathers are dead or totally or permanently disabled. The staff of the section consists of the supervisor who is also Secretary to the Child Welfare Board, two workers covering the Greater Winnipeg area, and three clerks. Part of the time of twelve generalized workers assigned to districts covering the entire Province outside Greater Winnipeg is also devoted to this work.

Application for mothers' allowance is made to the local Child Welfare Committee or in the absence of such a committee to the secretary-treasurer of the municipality. In unorganized territory, application for enrollment may be made to the Director of Child Welfare. All applications are forwarded to the Director, and after their receipt a social service worker from the Division visits the home and makes a social and financial investigation. The Supervisor prepares for the monthly Child Welfare Board meeting detailed information concerning each applicant with the recommendations of the Division. The Board decides whether applicants are eligible and, if eligible, the amount to which they are entitled. The allowance is budgeted for the family, and a maximum amount prescribed for each item.

There may be disagreement between the Division which makes the recommendation and the Board which grants the allowance. The Division Staff is trained in evaluating the factors involved in social welfare. The board members, lacking this training, may question the judgment of the Division staff. An annual joint meeting of board and staff, arranged by the Division Supervisor, has been found conducive to a better understanding of such issues.

The present trend in public welfare administration is to place the full responsibility for executing provisions of statutes, rules and regulations in the hands of properly qualified staff members. However, the need for an advisory board is generally recognized. Its functions should be consultative, judiciary and policy-forming but not executive. One of the most important duties of such a board is to help interpret the Department programs to the public, stressing problems, objectives, services, and needs.

After the Board has approved rules and regulations governing eligibility and minimum and maximum grants, the trained staff should decide upon individual eligibility and the amount to be allowed in each case. The field worker now spends considerable time making special reports for the board. Under the proposed arrangement this will no longer be necessary and the worker will have more time in the field.

Division of Child Care and Protection. The Division of Child Care and Protection is responsible for administering Part IV of the Child Welfare Act which is concerned with neglected children.

Neglected children are referred to Childrens' Aid Societies in areas covered by such societies. In other parts of the province, this is done by persons attached to the Division. There is one specialized worker in Winnipeg, and twelve generalized workers in other parts of the province give part of their time to this Division.

Legal Supervision. This section helps to administer Part VIII of the Child Welfare Act which is concerned with Adoption of Children, and that portion of Part V of the Act concerned with children born out of wedlock. One specialized worker in the Greater Winnipeg area specializes in adoption work. The twelve generalized social service workers attached to the Department give as much of their time as needed to this activity in other parts of the province.

Public Welfare Personnel. The Public Welfare program should, of course, take care of the material needs of persons unable to provide for themselves, but this is not the ultimate objective of social planning. There should be analysis and elimination, if possible, of the factors causing dependency. In other words, ways and means should be provided by which individuals and families may become self-supporting.

The routine of making grants of funds to individuals year after year is fairly simple. Such grants are of temporary benefit, however, and must be repeated at regular intervals. The study and elimination of the factors causing dependency take a much longer time but the results are more apt to be lasting. It is recognized that a certain percentage of the population, especially in the young and old age groups, will always be dependent. However, this portion of the population should also have the benefit of social planning.

The most important single factor in the success of the public welfare program will be the personnel. The Department of Health and Public Welfare should have in its employ a sufficient number of qualified social service workers to help plan programs and make field investigations not only for its own Bureaus, divisions, and sections, but for other provincial departments participating in public welfare activities. Among the social services for which trained personnel should be available are:

Social Assistance in Unorganized Territory.
Grants to Charitable Institutions.
Child Care and Protection.
Legal Supervision of Illegitimacy and Adoptions.
Mothers' Allowances.
Old Age Pensions.
Pensions to the Blind.
Rural Rehabilitation.
Unemployment Relief in Unorganized Territory.

The Provincial Department of Health and Public Welfare employs for its welfare activities three persons in charge of divisions, three supervisors, one of whom is also assistant director of Child Welfare, one inspector and thirteen social workers, two inspectresses and twenty stenographer clerks. Social service personnel on the staffs of the six Children's Aid Societies assist with the Child Care and Protection program.

For the purpose of administering the child welfare program, the province has been divided into ten districts with the central office in Winnipeg and branch offices with one worker each at Flin Flon and Brandon and with two workers at Dauphin. The remainder of the social service personnel uses the central office as headquarters. This would appear to be justified at present because the highways all radiate from Winnipeg, and there are few crossroads.

The supervisors and five of the social service workers carry specialized programs. The other eleven social service staff members are generalized workers. It would be difficult to estimate the number actually needed at present to administer the entire provincial welfare program. If a generalized public health nursing and welfare service were available to all departments and divisions, especially in the rural territory, it would be possible to make the districts much smaller and to have more branch offices with personnel in residence. This would be less costly to the province and more satisfactory to cases receiving help. Consideration should be given to training field workers for this purpose.

The success of the public welfare program will depend upon a number of factors among which are successful public and interdepartmental relations, coordination of health and welfare activities, a well planned in-service training program including regular staff meetings, and adequate funds with which to employ sufficient qualified personnel. It would seem that the authority granted under the present welfare legislation is sufficiently broad to permit the formulation of necessary rules and regulations for the proper administration of public welfare activities.

The services outlined in the section on Health Education should be available to persons participating in the welfare program. The welfare staff should take an active part in the recommended Health and Welfare Education Council, in the regional meetings of persons engaged in public health and welfare and in the staff meetings of the entire Department. Publicity for the welfare program should be released through the press, department publications, the radio, printed material and other channels. The specialist to be appointed in the Bureau of Health and Welfare Education should be available as a consultant to the welfare staff. The Child Welfare Division already holds regular staff meetings and has an in-service training

program. These activities ought to be extended to include all welfare personnel.

A manual should be compiled, including laws, policies, principles, objectives, functions, relationships and services in the field of public welfare. It should be so presented that new welfare staff members, department personnel, and agency members will be able after short study, to obtain a working knowledge of the Welfare Branch and its activities. It should describe specific services and indicate the steps to be taken in procuring and utilizing such services. This should become the Welfare Section of the Manual of the Department of Health and Public Welfare.

It is recommended:

1. THAT THE MINISTER OF HEALTH AND PUBLIC WELFARE BE MADE EX OFFICIO MEMBER, AND THE DEPUTY MINISTER THE EXECUTIVE MEMBER. OF THE WELFARE SUPERVISION BOARD.

2. THAT A PERSON QUALIFIED BY PERSONALITY, TRAINING AND EXPERIENCE BE APPOINTED TO DIRECT THE BRANCH OF PUBLIC WELFARE UNDER THE SUPERVISION OF THE DEPUTY MINISTER OF HEALTH AND PUBLIC WELFARE.

   (See organization chart, page 26A.)

3. THAT ACTIVITIES AND FACILITIES AND PLANTS OF CHARITABLE INSTITUTIONS BE EVALUATED BY TRAINED PERSONNEL AS A BASIS FOR THE RECOMMENDATION OF FINANCIAL GRANTS BY THE WELFARE SUPERVISION BOARD.

4. THAT PERSONS, GROUPS, OR PRIVATE AGENCIES, DESIRING TO BE INCORPORATED FOR PUBLIC WELFARE PURPOSES, BE INVESTIGATED BY TRAINED PERSONNEL AND THAT THE FINDINGS BE PRESENTED TO THE WELFARE SUPERVISION BOARD FOR ACTION.

5. THAT THE CHILD WELFARE BOARD BECOME THE STANDING COMMITTEE ON CHILD WELFARE OF THE WELFARE SUPERVISION BOARD.

6. THAT THE ASSISTANT DEPUTY MINISTER IN CHARGE OF PUBLIC WELFARE BE APPOINTED THE EXECUTIVE MEMBER OF THE CHILD WELFARE BOARD.

7. THAT THE REORGANIZED CHILD WELFARE BOARD BE ASSIGNED DUTIES OF AN ADVISORY NATURE.

8. THAT THE MEMBERS OF THE CHILD WELFARE BOARD BE ELECTED, TO SERVE IN ROTATION FOR A PERIOD OF THREE YEARS WITH OVER-LAPPING TERMS, AND THAT THEY SHALL NOT BE ELECTED FOR MORE THAN TWO CONSECUTIVE TERMS WITHOUT THE LAPSE OF A YEAR.

9. THAT THE ASSISTANT DEPUTY MINISTER IN CHARGE OF PUBLIC WELFARE BE APPOINTED DIRECTOR OF CHILD WELFARE.

10. THAT THE MINISTER, WITH THE APPROVAL OF THE BOARD, APPOINT FOR EACH MUNICIPALITY OR DISTRICT IN UNORGANIZED TERRITORY, A CHILD HEALTH AND WELFARE COMMITTEE OF FIVE MEMBERS TO SERVE IN ROTATION FOR THREE YEARS WITH OVER-LAPPING TERMS: THAT MEMBERS SHALL NOT BE ELIGIBLE FOR RE-ELECTION UNTIL AFTER THE LAPSE OF ONE YEAR AND THAT, IN ANY AREA SERVED BY A FULL-TIME MEDICAL HEALTH OFFICER, SUCH COMMITTEE MEMBERS BE CHOSEN FROM A LIST SUPPLIED BY THE MEDICAL HEALTH OFFICER.

11. THAT ELIGIBILITY FOR MOTHERS' ALLOWANCE AND THE AMOUNT OF THE GRANT BE DECIDED BY THE PROFESSIONAL STAFF IN ACCORDANCE WITH RULES AND REGULATIONS ESTABLISHED BY THE CHILD WELFARE BOARD.

12. THAT GENERALIZED SOCIAL WORKERS OF THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE BE MADE AVAILABLE ON REQUEST TO ALL PROVINCIAL DEPARTMENTS.

13. THAT IMMEDIATE STEPS BE TAKEN TO PREPARE AND TRAIN A COMPLETELY GENERALIZED FIELD STAFF IN PUBLIC HEALTH NURSING AND WELFARE FOR OUTLYING AREAS.

14. THAT THE FIELD WORK OF THE DIVISION OF SOCIAL ASSISTANCE IN UNORGANIZED TERRITORY BE PERFORMED BY TRAINED AND EXPERIENCED PERSONNEL.

15. THAT AN IN-SERVICE TRAINING PROGRAM INCLUDING REGULAR STAFF MEETINGS BE PLANNED FOR ALL WELFARE PERSONNEL.

16. THAT A PUBLIC WELFARE MANUAL BE PREPARED, WHICH SHOULD BECOME THE WELFARE SECTION OF A MANUAL FOR THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE.

17. THAT CONSIDERATION BE GIVEN TO THE TRANSFER OF OLD AGE PENSIONS AND PENSIONS FOR THE BLIND FROM THE ATTORNEY GENERAL'S DEPARTMENT TO THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE.

18. THAT THE WELFARE ACTIVITIES OF THE DEPARTMENT BE REORGANIZED AS A SECTION OF PUBLIC WELFARE UNDER THE DIRECTION OF A QUALIFIED DEPUTY MINISTER WITH BUREAUS OF (*a*) SOCIAL ASSISTANCE IN UNORGANIZED TERRITORY; (*b*) GRANTS TO CHARITABLE INSTITUTIONS AND (*c*) CHILD WELFARE: AND THAT THE CHILD WELFARE ACTIVITIES BE REORGANIZED IN DIVISIONS OF MOTHERS' ALLOWANCE, CHILD CARE AND PROTECTION, AND LEGAL SUPERVISION OF ILLEGITIMACY AND ADOPTIONS. (See organization chart, page 26A.)

Elementary school teachers are expected to teach health either as a separate subject or as an integral part of other subjects. The quality and quantity of health teaching varies, as in all provinces and states. Health should be one of the cardinal objectives of education. This is not so in Manitoba.

The great majority of teachers in Manitoba were trained in Manitoba Normal Schools or the University of Manitoba. Relatively few come from other areas, principally because salaries are too low to attract them. While recent graduates have received some instruction in health education, this is not true for those of an older generation, nor is there any requirement or provision for such training.

Cooperation between the Provincial Departments of Education and Health and Public Welfare is excellent. Unfortunately, however, the Department of Health and Public Welfare performs certain functions which are clearly within the duties of the Department of Education. For example, a public health nurse, loaned from the Department of Health and Public Welfare, has been giving courses in health education to teachers in training at Normal Schools in Winnipeg and Brandon, and to students of education at the University of Manitoba.

Moreover all these students were given physical examinations by the Director of Maternal and Child Health and Health Education of the Department of Health and Public Welfare. This type of service may have been justified as a means of developing the program, but its continuance cannot be defended since it should be a responsibility of the Department of Education. The Department of Health and Public Welfare is qualified to give physical examinations but because of its very limited medical staff it should not be called upon to sacrifice the time required for the examination of all studen teachers. Such examinations should indeed be required, but to provide them should be the function of the Department of Education. While the University of Manitoba insists on physical examinations of normal school students and students of education, there is no regulation requiring teachers or other school employees to be examined either at the time of employment or periodically thereafter.

In teaching health either to children or teachers in training, the Department of Health and Public Welfare is quite out of its field, particularly when this service may have to be furnished by persons with no pedagogical training. Good teaching requires specific preparation, and the public health nurse or physician who undertakes teaching without this background is exceeding proper bounds as much as the teacher who encroaches on the field of medicine or public health nursing.

A qualified teacher of health should have, first, sound training in pedagogy and, secondly, a sufficient knowledge of health, in all its aspects including mental hygiene, to teach it adequately. Obviously, such a person should come from and be a part of the educational system. The Department of Health and Public Welfare can and should assist the teacher by supplying health information and source material but should not undertake the actual function of teaching.

The Committee on Curriculum Planning has appointed a subcommittee on health to prepare courses for health teaching in elementary schools. The responsibility for developing the curriculum for health teaching devolved, as things turned out, upon one member, the Director of Health Education of the Provincial Department of Health and Public Welfare. To be sure, the course of health study was presented to the subcommittee for consideration and approval, and later to the Curriculum Planning Committee but the actual work was done by one person. It is assumed that this was never the intention of the committee, and that the duty of framing the course should have been shared by all the members of the subcommittee.

In order to develop a more effective program of health teaching, to place educational responsibilities in the Department of Education, and to aid in protecting the health of school children through protecting the health of school employees, it is recommended:

1. THAT THE DEPARTMENT OF EDUCATION ADD TO ITS PERMANENT STAFF A PERSON OR PERSONS TRAINED IN PEDAGOGY AND WITH SPECIAL TRAINING IN HEALTH, INCLUDING MENTAL HYGIENE, TO GIVE COURSES IN HEALTH EDUCATION TO NORMAL SCHOOL STUDENTS AND STUDENTS OF EDUCATION AT THE UNIVERSITY OF MANITOBA.

2. THAT THE DEPARTMENT OF EDUCATION REQUIRE ALL TEACHERS WHO HAVE NOT HAD SPECIAL COURSES IN HEALTH EDUCATION, INCLUDING MENTAL HYGIENE, TO TAKE SUCH COURSES WITHIN THE NEXT TWO YEARS AS A REQUISITE FOR RETAINING THEIR TEACHING CERTIFICATES.

3. THAT THE DEPARTMENT OF HEALTH AND PUBLIC WELFARE ASSIST TEACHERS OF HEALTH EDUCATION AND ELEMENTARY SCHOOL TEACHERS BY FURNISHING HEALTH INFORMATION WITH LOCAL APPLICATION WHEREVER POSSIBLE, AND SOURCE MATERIAL FOR TEACHING PURPOSES.

4. THAT THE SUBCOMMITTEE ON HEALTH OF THE CURRICULUM PLANNING COMMITTEE BE SO CONSTITUTED AS TO ASSURE ACTIVE PARTICIPATION ON THE PART OF ITS PERSONNEL, AND THAT IT INCLUDE NOT ONLY REPRESENTATION FROM THE FIELDS OF EDUCATION AND PUBLIC HEALTH, INCLUDING MENTAL HYGIENE, BUT POSSIBLY ALSO MEMBERS FROM THE MEDICAL, DENTAL AND NURSINC ASSOCIATIONS.

5. THAT THE DEPARTMENT OF EDUCATION CONTINUE ITS POLICY OF REQUIRING THE PHYSICAL EXAMINATION OF ALL NORMAL SCHOOL STUDENTS AND STUDENTS OF EDUCATION AT THE UNIVERSITY OF MANITOBA BUT MAKE ITS OWN PROVISION FOR SUCH EXAMINATIONS.

6. THAT ALL TEACHERS AND ALL OTHER SCHOOL EMPLOYEES BE REQUIRED TO HAVE A COMPLETE PHYSICAL EXAMINATION AS A PREREQUISITE TO EMPLOYMENT, AND PERIODIC EXAMINATIONS EVERY TWO YEARS THEREAFTER.

Original examination should include chest x-ray or tuberculin tests, followed by x-ray if positive. If x-ray plate shows any suspicious signs, the employee should be re-x-rayed at the end of three months and as often thereafter as prescribed by the examining physician. A school employee found to have active tuberculosis should not be dropped but given a leave of absence with the assurance of tenure if cured or arrested.

VOLUNTARY AND SEMI-GOVERNMENTAL AGENCIES

TUBERCULOSIS

Tuberculosis Control in Manitoba is a province-wide activity. There is a cooperative plan by which the public health nurses of the Provincial Department of Health and Public Welfare and the nurses of full-time local health departments assume the responsibility for tuberculosis follow-up work. The responsibility for case finding, diagnosis, and, to a considerable extent, treatment is vested in the Sanatorium Board of Manitoba. This Board, established in 1910, is in reality a semi-governmental agency. The Board consists of some twenty-nine members, nine of whom are statutory members, and the others elected for indefinite terms of office. Statutory members include three representatives from the Provincial Department of Health and Public Welfare, the Municipal Commissioner, two representatives of the Union of Manitoba Municipalities, and one each from the King Edward Hospital, the St. Boniface Sanatorium, and the Manitoba Division of the Canadian Medical Association. Eight members of the present board are physicians. There is an executive board of five members—the chairman, vice-chairman, the chairmen respectively of the Administrative and Finance Committees, and the secretary-treasurer. Full meetings are held every three months, and the committees on finance and administration meet monthly.

The Medical Advisory Committee, established over a year ago, is composed of the medical members of the Sanatorium Board, the superintendents of all institutions caring for the tuberculous, the Deputy Minister of Health and Public Welfare, the provincial epidemiologist, and the health officer of Winnipeg. This body is conducting a survey of surgical patients in sanatoria throughout the province and a study of the care of tuberculosis spreaders and the problem of segregation which should prove valuable.

The Sanatorium Board functions through its executive director (known as the medical superintendent), and an assistant medical superintendent. The principal duties of the Board include the conduct and management of:

1. The Central Tuberculosis Clinic in Winnipeg;
2. The traveling tuberculosis clinics conducted monthly in Brandon, Dauphin, Portage la Prairie and Selkirk, and annually or semi-annually in some forty other centers;
3. The Manitoba Sanatorium at Ninette;
4. The Dynevor Indian Hospital at Selkirk;
5. The Christmas Seal campaign.

The Sanatorium Board cooperates with other tuberculosis sanatoria, including the St. Boniface and the King Edward Hospital. The practice of having periodic meetings of the medical staffs of all institutions caring for the tuberculous is to be commended.

There is an excellent Central Tuberculosis Registry conducted by the Provincial Department of Health and Public Welfare in cooperation with the Sanatorium Board.

Except for a follow-up service provided by public health nurses of the Provincial Department of Health and Public Welfare and the four local health departments, tuberculosis control in Manitoba is financed through:

(*a*) The Christmas Seal campaign, the proceeds of which are used for the traveling clinics and for education in tuberculosis control and prevention;

(*b*) A tax levy for tuberculosis hospitalization, applied to all municipalities on an equalization basis;

(*c*) The payment by the Province of 50 cents per diem of care for all tuberculosis cases hospitalized at public expense, which includes almost all cases, plus an additional $1.80 per diem for cases residing in unorganized or disorganized territory.

(*d*) The payment of an additional $1.80 per diem for their residents by the cities of Winnipeg, Brandon, St. Boniface and Portage la Prairie.

Per diem payments for city cases and for cases from unorganized areas, amount to $2.30:—$1.80 from the city and 50 cents from the province, which covers the cost of hospitalization. On the other hand, the tax levy for the hospitalization of tuberculous cases from the municipalities fails to cover the cost and results in a substantial annual deficit. This constitutes a serious situation which must be remedied if adequate care is to be continued.

The traveling clinics are held monthly in Brandon, Dauphin, Portage la Prairie and Selkirk, and at least annually in some thirty-five other communities. Previous to 1941 there were forty other clinics. These, together with the Central Clinic in Winnipeg are conducted by the Sanatorium Board.

In addition to the Central Clinic in Winnipeg, which is open for six hours every week-day except Saturday, to eligible persons throughout the province, outpatient chest clinics are held at the Ninette Sanatorium, the King Edward Hospital in Winnipeg, and at St. Boniface Hospital (not the Sanatorium).

In 1940, the traveling clinics made 7,319 examinations and the Central Clinic 5,260. There were 1,047 examinations at the outpatient clinic of the Manitoba Sanatorium at Ninette, 1,041 at St. Boniface Hospital and 1,230 at King Edward Hospital. Except in the Manitoba Sanatorium, a large percentage of the visits was for

pneumothorax treatments. It is interesting to note that of the 484 new tuberculosis cases discovered in 1940 through the 15,897 examinations at these various clinics, 242 were diagnosed through the traveling clinics and 212 by the Central Clinic, making altogether 454 or 93.8 per cent of the total, discovered through these two sources. In 1940, a provincial total of 713 new cases was reported. The 484 found by the various clinics thus represent 67.9 per cent of all cases reported in 1940.

Hospital care for the tuberculous is provided at the following institutions:

Name of Institution	Location	Bed Capacity
Manitoba Sanatorium	Ninette	285
St. Boniface Sanatorium	St. Vital	280
King Edward Hospital (City patients only)	Winnipeg	125
Total exclusive of hospitals for Indians and the Central Clinic		690
Central Clinic, Winnipeg (for observation, diagnosis and early treatment only)	50 beds	
BEDS FOR INDIANS		
Dynevor	Dynevor	50
In institutions at Pine Falls, Fisher River and Norway House	about	50
Total beds for Indians	about	100
Total beds for tuberculosis, exclusive of the Central Clinic which is a clearing house only		790

In 1940, there were 359 deaths from tuberculosis. On the basis of 790 beds, this gives a ratio of 2.2 beds per death. White deaths totalled 211 which with 690 available beds, gives a ratio of 3.2 beds per death. Indian deaths totalled 148 which with about 100 available beds, gives a ratio of 0.68 beds per death. The estimated Indian population is 15,000.

A ratio of 2 beds per annual average death is generally considered a reasonable standard. Thus it would appear that Manitoba has a fairly adequate number of beds for white tuberculous patients while the accommodation for Indians is very inadequate.

All institutions take all types of cases except the Manitoba Sanatorium which does not provide for children. Most of the children are cared for at St. Boniface although, unfortunately, some are cared for at the Central Tuberculosis Clinic. All institutions do tuberculosis surgery except the Central Tuberculosis Clinic, which confines itself to pneumothorax.

Although in the past there have been waiting lists, there is none at present in the institutions caring for white patients.

Tuberculosis is still widespread in Manitoba and a serious problem, notwithstanding the fact that the death rate is relatively low. The rate in 1940 was 51.28 per 100,000 population, 30.8 for whites, but for Indians 986.7. Obviously, among the Indians tuberculosis is a very grave menace.

On the whole, the tuberculosis control program in the province is good, and except for Indians, fairly ample. However, there are many weaknesses which should be corrected. Certain points may be especially noted:

1. While the Manitoba Sanatorium Board unquestionably is doing very good work, it is undertaking responsibilities usually vested in the official health department. As the Provincial Tuberculosis Association affiliated with the Canadian Tuberculosis Association, the Board does commendably except that it might well expand its educational program and develop facilities for post sanatorium care and rehabilitation. As the Provincial Tuberculosis Association, the Sanatorium Board conducts the Seal campaign, educational work in behalf of tuberculosis control and the traveling clinics.

   The fact that the Sanatorium Board is so designated is unfortunate because today its functions are much broader and more comprehensive than the name implies. While the program has changed and developed, the interests of the Board have not expanded conformably. According to the available evidence, the Manitoba Sanatorium Board still thinks and acts as a board for the Manitoba Sanatorium, Ninette, regarding the other features of the program as subsidiary. All those interested in the broad aspects of the tuberculosis control program or affiliated with other institutions caring for the tuberculous, feel and resent this bias, which even members of the Board itself admit.

2. *The Central Tuberculosis Clinic* housed in a separate building near the grounds of the Winnipeg General Hospital is open to the public from 9 to 12 and from 2 to 5 every day except Saturday and Sunday. While most of its patients naturally come from the Winnipeg area, a great many are sent in from the traveling clinics. Visits to the clinic are by appointment. While heartily approving the principle of conducting clinic visits by appointment, it is our firm conviction that new patients should invariably be examined at the first visit.

   The same holds true with respect to the requirement of the clinic that all patients, except contacts, must be referred by a physician. While public health authorities should do everything within reason to protect the rights of the individual physician, one should remember that tuberculosis, like syphilis and gonorrhea, is a dangerous communicable disease, which if not diagnosed immediately, may result in the spread of the disease. No new patient, who after all is a potential spreader of tuberculosis, should be permitted to leave the clinic without having had the examination for which he presented himself. To require a written referral from a physician unquestionably results in some missed cases of tuberculosis.

3. *The Central Tuberculosis Clinic Infirmary* has 50 beds of which 17 are set aside for the care of children. This unit of 50 beds is intended to be used for observation, diagnosis and early treatment. The established policy is that patients admitted should be transferred to other institutions within a month. As a matter of fact, most patients stay at the Central Clinic considerably more than a month. On August 12,

1941, there were 40 beds occupied, 27 by adults and 13 by children. Of the 13 children under sixteen, 6 had been there over a year. The quarters are not at all suitable for the care of children. Since there is at present no waiting list in any of the tuberculosis institutions, there would seem to be no need for detaining patients more than a few days, especially as the diagnosis of tuberculosis can be made promptly in most cases. There seems no need for so many beds particularly if children are not accepted for treatment.

Once the case is diagnosed as tuberculosis, even though the degree of activity and consequently the type of treatment has not been determined, there would seem no reason why that case should not be transferred to another institution, where the appropriate type of treatment may be decided on and administered. Generally speaking, the Central Tuberculosis Clinic should diagnose the case and arrange for immediate transfer to another institution. Only moribund cases and the occasional patient needing some special service which can be provided only at the Winnipeg General Hospital, should be hospitalized at the Central Clinic.

Keeping patients at the Central Clinic longer than is strictly necessary leads to a further complication. Patients are permitted a choice of hospital instead of being transferred to whatever one has a bed available. They hear comments about the various institutions, usually favorable to Ninette and unfavorable to the King Edward and St. Boniface, and this determines their preference, leading to an uneven distribution of cases. This situation could be overcome by:

(*a*) Assigning patients to other institutions immediately, or after at most a few days' stay in the clinic.

(*b*) Transferring patients, regardless of preference, to institutions having available beds.

(c) Reducing the number of beds in the Clinic from fifty to twenty-five or less. This will aid in effecting the changes suggested in "*a*" and "*b*".

The Tuberculosis Commission (hereafter recommended) should make a determined effort to stop harmful criticism, first, by investigating all complaints and correcting undesirable conditions, and second, by conducting an educational program designed to correct false impressions.

4. *Positive Sputum Cases.* The following information taken from a report of the Central Tuberculosis Registry, dated July 25, 1941, is interesting and perhaps significant:

Tuberculosis Patients Outside Winnipeg:

53 patients at home known to have positive sputum.
8 have never had Sanatorium treatment.
21 left Sanatorium against advice.
2 from the Central Tuberculosis Clinic.
4 from Ninette.
2 from Municipal Hospitals.
13 from St. Boniface Sanatorium.
3 cannot be located.

Date of last positive sputum:

25	1941
12	1940
7	1939
6	1938
3	1937

This information gives rise to two questions: First, why are 53 patients known to have positive sputum living at home when there is no waiting list at the tuberculosis institutions? Second, why did the St. Boniface Sanatorium contribute 13, or 61.9 per cent of the 21 patients leaving Sanatoria against advice?

Of the 53 patients with positive sputum living at home, 21 or 39.6 per cent left institutions against advice; 8, or 15.1 per cent, have never had sanatorium treatment; 3, or 5.7 per cent, could not be found, so presumably 21, or 39.6 per cent left the sanatoria with the consent of the institution. Why were patients with positive sputum discharged with consent? Is it due to wide differences of opinion in the several institutions as to what constitutes "discharge with consent", or were there actually so many cases that could be discharged safely? Conclusions based on brief descriptions of these cases and their home background are that of the 53 cases at least 18 have unsatisfactory home conditions; 18 might perhaps live in reasonable safety at home; 16 gave insufficient information or none at all, and one has died lately. The recent amendment to the tuberculosis regulations, which makes it possible to enforce hospitalization, should prove helpful in correcting this condition, but it will not solve the problem if one or more of the institutions is lax in permitting discharges.

These are merely samples of questions which the Tuberculosis Commission should assist in solving.

5. *The King Edward Hospital.* It is often difficult to persuade patients to accept hospitalization at the King Edward Hospital because of its early history when it chiefly harbored cases in the last stage of the disease. Even today, many prospective patients feel that the King Edward Hospital is the place where one is sent to die. As a result, the King Edward Hospital is frequently unable to make the most effective use of its facilities. The most logical solution to this problem would be to require the admission of all Winnipeg tuberculosis cases to institutional care through the King Edward Hospital,— in other words to admit all Winnipeg cases temporarily to the King Edward and later graduate to St. Boniface and Ninette those who might benefit by reasonably prolonged care. The King Edward would then retain only the less hopeful cases and those needing major surgery. The surgical cases would eventually be transferred to other institutions.

6. *The Tuberculosis Tax Levy.* As has been said, the tax levied on municipalities for tuberculosis hospitalization is insufficient. The levy should be raised sufficiently to pay for such care.

7. *The Central Tuberculosis Registry.* The Central Tuberculosis Registry, which is conducted as a joint undertaking of the Sanatorium Board and the Provincial Department of Health and Public Welfare, appears to be functioning splendidly with the notable exception that it does not have information on City of Winnipeg cases. All published figures are specified "Exclusive of the City of Winnipeg". The Division of Communicable Disease of the Winnipeg City Health Department is to be criticized for not supplying information to the Sanatorium Board and the Central Registry.

8. *The Manitoba Sanatorium at Ninette.* The Sanatorium at Ninette does not provide care for tuberculous children, although the surroundings would be suitable. Since the Central Tuberculosis Clinic which accepts children, is not a desirable place for them, it would seem logical to accommodate such cases at Ninette.

   At present, the Manitoba Sanatorium, Ninette, is headquarters for the traveling clinics. There is some criticism of this arrangement on the grounds that the traveling clinics are conducted as an adjunct to the Manitoba Sanatorium rather than as a Province-wide case-finding program. Once the Tuberculosis Commission has been established and the beds at the Central Tuberculosis Clinic have been reduced, it would seem wise to employ the Central Clinic as headquarters for the Commission and the Travelling Clinics rather than Ninette.

9. *The Indian Tuberculosis Problem.* As stated previously, although the tuberculosis control program for Indians has been markedly improved during the past few years, it is still woefully inadequate. The traveling clinics serve Indians as well as whites. The difficult problem is to provide hospital care for tuberculous Indians. It has been noted that only 0.68 beds per annual death are available as compared with a reasonable standard of two. If the Department of Indian Affairs is not at present able to provide additional beds, it is suggested that arrangements might be made to use available beds in other institutions on a mutually satisfactory per diem basis.

   Among the Indians, rehabilitation presents an even more difficult problem than among the whites. Information leads to the belief that a great many young Indians would be happy to break away from the influence of the older generation. If the government were to institute a housing project, and supply land, materials and supervision, letting the Indians supply the labor, the problem might be well on the way to solution. The coming generation might then enjoy a higher standard of living, with the likelihood that general health would improve and the spread of infection show a marked decrease.

10. *General Rehabilitation.* No agency in Manitoba is carrying on a comprehensive post-sanatorium and rehabilitation program for the tuberculous. There is need for such a program and it might well be instituted by the Tuberculosis Control Commission hereafter recommended.

In order to correct some of the weaknesses and solve some of the difficulties pointed out in preceding pages, it is recommended:

1. THAT FULL-TIME HEALTH UNITS OR DEPARTMENTS NOW IN EXISTENCE OR HEREAFTER ESTABLISHED ASSUME RESPONSIBILITY FOR THEIR OWN TUBERCULOSIS CONTROL AND PREVENTION PROGRAMS, WITH ONLY SUCH CONSULTATIVE OR OTHER SERVICES FROM THE MANITOBA TUBERCULOSIS CONTROL COMMISSION (hereafter to be recommended) AS MAY BE NECESSARY TO THE EFFECTIVE FUNCTIONING OF SUCH PROGRAMS.

2-*a*. THAT THE MANITOBA SANATORIUM BOARD BE ABOLISHED, AND, IN ITS PLACE, THE LIEUTENANT-GOVERNOR-IN-COUNCIL APPOINT A MANI-

TOBA TUBERCULOSIS CONTROL COMMISSION TO BE COMPOSED OF THE NINE STATUTORY MEMBERS AS NOW PRESCRIBED ON THE SANATORIUM BOARD AND FIFTEEN OTHER MEMBERS TO BE APPOINTED FOR THREE-YEAR TERMS.

At the expiration of their three-year terms members may be eligible for re-election for a second three-year term, but shall not serve for more than two consecutive three-year terms without the lapse of a year.

b. THAT THE MANITOBA TUBERCULOSIS CONTROL COMMISSION EMPLOY AS DIRECTOR A FULL-TIME PHYSICIAN TRAINED AND EXPERIENCED IN TUBERCULOSIS CONTROL, AND SUCH OTHER PERSONNEL AS MAY BE NECESSARY, SUCH DIRECTOR AND OTHER PERSONNEL NOT TO ACCEPT EMPLOYMENT OR SPECIFIC ADMINISTRATIVE DUTIES IN ANY TUBERCULOSIS INSTITUTION EXCEPT THE TUBERCULOSIS CENTRAL CLINIC.

c. THAT THE BASIC FUNCTIONS OF THE MANITOBA TUBERCULOSIS CONTROL COMMISSION BE:

1. TO CONDUCT THE CENTRAL TUBERCULOSIS CLINIC IN COOPERATION WITH THE TUBERCULOSIS BUREAU OF THE WINNIPEG CITY HEALTH DEPARTMENT;

2. TO CONDUCT THE TUBERCULOSIS TRAVELING CLINICS;

3. TO DEVELOP THROUGHOUT THE PROVINCE AN EDUCATIONAL PROGRAM FOR TUBERCULOSIS CONTROL AND PREVENTION;

4. TO RENDER CONSULTATION, ADVISORY AND SUPERVISORY SERVICES TO INSTITUTIONS CARING FOR THE TUBERCULOUS THROUGHOUT THE PROVINCE;

5. TO SET UP MINIMUM UNIFORM STANDARDS FOR THE CARE OF THE TUBERCULOUS IN ALL TUBERCULOSIS INSTITUTIONS, AND TO PLAN WITH SUCH INSTITUTIONS FOR THE MOST EFFECTIVE USE OF AVAILABLE FACILITIES.

d. THAT THE MEMBERS OF THE TUBERCULOSIS CONTROL COMMISSION FUNCTION AS THE JUDICIARY, ADVISORY, POLICY-FORMING BRANCH

OF THE COMMISSION, AND THE MEDICAL DIRECTOR (WHOSE TITLE MIGHT WELL BE TUBERCULOSIS COMPTROLLER) AND HIS STAFF FUNCTION AS THE EXECUTIVE BRANCH.

3. THAT A NEW BOARD, DISTINCT AND APART FROM THE TUBERCULOSIS CONTROL COMMISSION, BE APPOINTED BY THE LIEUTENANT-GOVERNOR-IN-COUNCIL TO ACT AS THE JUDICIARY, ADVISORY, POLICY-FORMING AGENCY FOR THE MANITOBA SANATORIUM AT NINETTE.

4. THAT THE NUMBER OF BEDS AT THE CENTRAL TUBERCULOSIS CLINIC BE REDUCED FROM 50 TO 25 OR LESS AND THAT NO CHILDREN BE CARED FOR AT THAT INSTITUTION.

5. THAT ALL WINNIPEG TUBERCULOSIS CASES BE ADMITTED TO HOSPITAL CARE AT THE KING EDWARD HOSPITAL.

   Those cases which might benefit by reasonably *prolonged care* at either St. Boniface Sanatorium or the *Manitoba Sanatorium* should be graduated to these institutions. Cases requiring major surgery probably should have such surgery at the King Edward *Hospital* before transfer. Graduation from the King Edward Hospital should be made upon recommendation of the Tuberculosis *Comptroller* of the Manitoba Tuberculosis *Control Commission.*

6. THAT THE MUNICIPAL TUBERCULOSIS TAX LEVY BE REVIEWED AND MADE ADEQUATE TO COVER THE COSTS OF TUBERCULOSIS CONTROL.

7. THAT THE SANATORIUM AT NINETTE PROVIDE CARE FOR TUBERCULOUS CHILDREN.

8. THAT THE TUBERCULOSIS CLINIC MODIFY ITS ADMISSION POLICY TO INSURE DIAGNOSTIC EXAMINATION OF ALL NEW PATIENTS BEFORE THEY LEAVE THE PREMISES.

   In the absence of *specific referral*, the examination report should be *sent to the patient's physician*, and the patient sent to that *physician to obtain* the information, so as to avoid any possible abrogation of physicians' *rights.*

9. THAT THE TUBERCULOSIS CLINIC INFIRMARY, EXCEPT WHERE IT MAY BE NECESSARY BRIEFLY TO HOLD A PATIENT PENDING ARRANGEMENTS FOR TRANSFER TO ANOTHER INSTITUTION, ACCEPT ONLY MORIBUND CASES AND THE OCCASIONAL PATIENT REQUIRING SPECIAL SERVICES WHICH CAN BE RENDERED ONLY AT THE WINNIPEG HOSPITAL.

10. THAT THE TUBERCULOSIS CONTROL COMMISSION, WITH THE ADVICE AND COUNSEL OF THE CANADIAN TUBERCULOSIS ASSOCIATION, INSTITUTE A POST-SANATORIUM AND REHABILITATION PROGRAM.

11. THAT THE DIVISION OF COMMUNICABLE DISEASE CONTROL OF THE CITY OF WINNIPEG HEALTH DEPARTMENT SUPPLY TO THE TUBERCULOSIS CONTROL COMMISSION AND THE CENTRAL TUBERCULOSIS REGISTRY ESSENTIAL INFORMATION TO COMPLETE THE PICTURE OF TUBERCULOSIS IN MANITOBA.

12. THAT THE DEPARTMENT OF INDIAN AFFAIRS ENDEAVOR TO INCREASE ITS FACILITIES FOR THE CARE OF THE TUBERCULOUS AND THAT IN THE INTERIM OF ATTAINING THIS OBJECTIVE CASES BE HOSPITALIZED IN INSTITUTIONS HAVING AVAILABLE BEDS, AT A MUTUALLY SATISFACTORY PER DIEM RATE.

13. THAT THE DEPARTMENT OF INDIAN AFFAIRS UNDERTAKE TO CARRY OUT THE RULES AND REGULATIONS OF THE MANITOBA DEPARTMENT OF HEALTH AND PUBLIC WELFARE GOVERNING TUBERCULOSIS, PARTICULARLY THE RECENT AMENDMENTS FOR THE ENFORCED HOSPITALIZATION OF POSITIVE SPUTUM CASES.

14. THAT THE DEPARTMENT OF INDIAN AFFAIRS, WITH THE COOPERATION OF THE PROVINCIAL AND NATIONAL AGENCIES DEVELOP A COMPLETE TUBERCULOSIS PROGRAM INCLUDING CASE-FINDING, TREATMENT AND AFTER-CARE.

THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION

The Manitoba Medical Association takes a keen and active interest in public health and in problems involving public medical care. It is justly critical but fair and broad minded, and has been of great assistance in assuring the sound development of the public health program.

Manitoba has approximately 550 practising physicians of whom 300 are in Winnipeg. Of the 250 outside of Winnipeg, nearly 170 are part-time health officers. This in itself indicates interest in public health developments.

The ultimate goal of public health endeavor is universal understanding, acceptance and practice of established procedures in disease prevention and health promotion. This goal will never be achieved until people are stimulated to ask for the services and the professional groups capable of rendering the services are ready and willing to provide them. The trend of public health effort is toward educating people to want and request those services which will help to prevent disease and promote sound health, and to render direct service only to those who cannot obtain them readily through their own resources. These services are:

(*a*) Full-time local health departments providing essential environmental protection services, such as water supply, sewage disposal, food and milk control, industrial hygiene and housing, and an educational program designed to stimulate a demand for prevention and health promotion services. Direct services should be provided for those unable to obtain them through their own resources.

(*b*) Medical, dental and nursing prevention and health promotional services for which the educational program of the health department creates a desire.

Each year more and more individuals seek guidance in disease prevention and health promotion from their own physicians, dentists and nurses. Unquestionably, this tendency will continue to spread as more local health departments are established and their educational efforts increase in effectiveness.

If this be true, the professional groups among whom the medical group is the largest and most important, must prepare to render the services requested, and many physicians are already equipped to do so.

As a further means of stimulating the people and assisting the medical profession to meet their growing demands, it is recommended:

1. THAT THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION INSTITUTE ON A REGIONAL BASIS A SERIES OF POSTGRADUATE

REFRESHER COURSES DESIGNED TO INCREASE INTEREST IN, AND ABILITY TO SUPPLY, ESSENTIAL SERVICES FOR THE PREVENTION OF DISEASE AND THE PROMOTION OF HEALTH.

2. THAT THE MEDICAL ASSOCIATION ASSIST THE PROVINCIAL AND LOCAL HEALTH DEPARTMENTS AND THE HEALTH EDUCATION COUNCIL IN FORMULATING A SOUND EDUCATIONAL PROGRAM TO DEVELOP IN THE PUBLIC A MORE GENERAL UNDERSTANDING AND APPRECIATION OF THESE SERVICES.

CANADIAN FOUNDATION FOR PREVENTIVE DENTISTRY

Organized under a federal charter, specifically "not for profit", the Canadian Foundation for Preventive Dentistry started its program in 1929. While established as a national agency, its activities thus far have been confined to Manitoba. Membership is open to any ethical dentist duly enrolled in the Association.

The Foundation has the backing and whole-hearted cooperation of the dental profession. As a matter of fact it is an outgrowth of a preventive dental program sponsored and conducted by the Manitoba Dental Association.

Although the Foundation is authorized to carry on through bulletins, radio and the press a comprehensive dental health and therefore public health education program, as well as to conduct clinics, its activities thus far have been confined largely to organizing and conducting dental clinics in rural areas, especially in districts far removed from dental service.

The Foundation is financed primarily through partial payment for services rendered in the clinics. It also receives some small grants from the Provincial Department of Health and Public Welfare, the Manitoba Dental Association, and the Canadian Dental Hygiene Council.

Clinics are held only upon the request and sponsorship of a local agency, such as the School Board, Women's Institute, or the United Farm Women of Manitoba. The sponsoring agency makes application for a clinic to the Canadian Foundation for Preventive Dentistry and agrees to abide by the regulations governing such clinics and to pay certain stipulated expenses.

In brief, the regulations provide:

(*a*) That the sponsoring agency will be responsible for providing suitable quarters for the clinic;

(*b*) That the clinic will be conducted during school hours;

(*c*) That all public school pupils in grades 1 to 8, are eligible for treatment and that preschool children will be attended whenever possible;

(*d*) That no adults will be treated at the clinic;

(*e*) That neither the dentist, the public health nurse nor the cooperating agency—Health Department, Red Cross, Mission Station or Hospital —shall be responsible for any details of financing.

The financial obligations of the sponsoring agency are:

(*a*) To pay a minimum of $20.00 for each clinic day;
(Until this year the charge was $15.00.)

(*b*) To furnish room and board for the dentist and nurse;

(*c*) To furnish transportation for the dentist to and from the clinic.

A public health nurse of the Department of Health and Public Welfare always assists at the clinic. During 1939, clinics operated by twenty-one dentists were held in forty-seven places. Altogether 108 schools were covered. Clinic days totalled 207.5, or slightly less than an average of two days per clinic. Altogether 4,165 patients were seen, of whom 2,914, or 70 per cent, were given treatment; thirty per cent needed no treatment.

This is a splendid program and merits the praise of all those interested in public health and dentistry. The only criticism is that the program is confined too largely to school children. While they are eligible for treatment, it would appear that the number of preschool children cared for represents but a very small proportion of the total. From the standpoint of preventive dentistry, the emphasis should be placed on the preschool child. Frequently children of preschool age can be reached by requiring that for every three children of school age, one preschool child must attend the clinic. The service should be extended also to reach prenatal and tuberculosis groups, as well as tuberculosis contacts.

It is hoped that the Canadian Foundation for Preventive Dentistry may find it possible to work with and through full-time local health departments and municipal doctors (as local health officers) in developing local programs designed primarily to reach children of preschool age.

Further to strengthen the program of public health dentistry, it is recommended:

1. THAT THE CANADIAN FOUNDATION FOR PREVENTIVE DENTISTRY ENDEAVOR TO INCREASE THE NUMBER OF PRESCHOOL CHILDREN REACHED THROUGH ITS CLINICS BY REQUIRING THAT FOR EVERY THREE SCHOOL CHILDREN CARED FOR THERE MUST BE AT LEAST ONE CHILD OF PRESCHOOL AGE.

2. THAT THE FOUNDATION GIVE CONSIDERATION TO INCLUDE IN ITS CLINICS PRENATAL GROUPS, CASES OF TUBERCULOSIS AND TUBERCULOSIS CONTACTS.

3. THAT THE FOUNDATION WORK WITH AND THROUGH FULL-TIME LOCAL HEALTH DEPARTMENTS AND MUNICIPAL DOCTORS (AS LOCAL HEALTH OFFICERS) IN DEVELOPING PROGRAMS DESIGNED PRIMARILY TO REACH CHILDREN OF PRESCHOOL AGE.

THE MANITOBA DENTAL ASSOCIATION

The Manitoba Dental Association has already given convincing evidence of its interest in preventive dentistry in that its members are responsible for having established the Canadian Foundation for Preventive Dentistry.

There are approximately 263 practising dentists in Manitoba. Since 190 of them are in Winnipeg, leaving but 73 for the remainder of the Province, it is apparent that rural Manitoba has a scarcity of dentists.

Just as with public health as a whole, so it is with public health dentistry: the goal of universal acceptance and practice of preventive procedures will never be achieved until the majority of the professional group is willing and able to render the necessary services. In dentistry this becomes an important problem because there appears to be a general reluctance to practice childhood dentistry.

Because adequate solution of this difficulty means so much to the future health of our citizens, it is hoped that the Manitoba Dental Association may find it possible to institute a province-wide program designed to stimulate dentists throughout the Province to an interest in and understanding of the practice of childhood dentistry.

To this end, it is recommended:

1. THAT THE MANITOBA DENTAL ASSOCIATION ENDEAVOR TO ESTABLISH, ON A REGIONAL BASIS, POSTGRADUATE REFRESHER COURSES DESIGNED TO INTEREST DENTISTS THROUGHOUT THE PROVINCE IN THE PRACTICE OF PREVENTIVE CHILDHOOD DENTISTRY.

2. THAT THE DENTAL ASSOCIATION CONTINUE AND ENLARGE ITS PROVINCE-WIDE LAY EDUCATIONAL PROGRAM DESIGNED THROUGH THE PRESS, RADIO, BULLETINS, EXHIBITS AND TALKS, TO INTEREST PARENTS IN HAVING REGULAR PERIODIC DENTAL CARE FOR THEIR CHILDREN, MOST ESPECIALLY THOSE OF PRESCHOOL AGE.

CANCER RELIEF AND RESEARCH INSTITUTE

Established some ten years ago as a voluntary agency, the Cancer Relief and Research Institute is actually a quasi-governmental agency in that the Provincial Government prescribes its basic functions and the organization of its Board. The government makes an annual grant to the Institute, provides quarters for it rent free, and also guarantees its bond.

The Board consists of eighteen members appointed as follows:

(*a*) The Minister of Health and Public Welfare and the President and Registrar of the College of Physicians and Surgeons of Manitoba, ex officio.

(*b*) Three members appointed by the Lieutenant-Governor-in-Council;

(*c*) Three members appointed by the University of Manitoba;

(*d*) Three members appointed by the Union of Manitoba Municipalities;

(*e*) Three members appointed by the Manitoba Division of the Canadian Medical Association; and

(*f*) Three members appointed by the Board.

Personnel, appointed and employed by the Board, includes the Director who is an exceptionally well-qualified and experienced physicist, two technicians, a laboratory helper, an office assistant, and a public health nurse loaned from the Provincial Department of Health and Public Welfare, making a total of six.

The budget of the Institute totals approximately $24,500.00. Of this amount nearly $7,000.00 is used toward paying off principal and interest on its $87,000.00 bond which was issued principally to purchase radium. This leaves an operating budget of about $17,500.00. Income is derived from grants by the Provincial Government through the Department of Health and Public Welfare, and from the Winnipeg Federated Budget Board, the Winnipeg Foundation, the Union of Manitoba Municipalities through the rental use of radium and from a Tag Day in rural Manitoba.

The Provincial Government has delegated very broad functions and authorities to the Cancer Relief and Research Institute, including the right to adopt measures for the relief or cure of cancer, to supply radium, to establish cancer clinics, to give public instruction regarding the treatment of cancer and to disseminate information which may aid in the control and successful treatment of cancer, to assist in correlating the work of other agencies having similar purposes, and to enter into agreements with hospitals for the provision of such services as may prove helpful to the cancer control program.

The Institute has been active to date in supplying radium, in conducting a province-wide educational program, and in research.

A biopsy service is available through the Institute to all physicians in Manitoba. Radium is supplied throughout the Province on a rental basis to those who can pay, and free to those who can not pay. Distribution is through a list of some 29 approved radiation specialists, although most of the work is done by a very few physicians. Research has consisted largely in studies of blood serum and developing pump tubes which can be operated cheaply for X-ray treatment.

There has been a great deal of discussion concerning the desirability of establishing a general radiation center. This would seem to be an important and highly desirable service but the Cancer Institute would need an annual guarantee of around $10,000.00 for some ten years in order to assure its successful operation.

Plans have also been discussed for stimulating Women's Clubs and other organizations to agree, as groups to undergo complete physical examination. The examinations would be made by local physicians paid at an agreed rate by the Cancer Institute upon receipt of a properly filled examination blank. This also promises to be a beneficial undertaking, but plans should be worked out carefully with the Manitoba Division of the Canadian Medical Association.

The educational efforts of the Cancer Institute, while well planned and conducted, seem to have been somewhat too greatly concerned with building up the prestige of the Cancer Institute. Perhaps this was regarded as necessary in the developmental stages of the Institute. Cancer control educational programs should not be conducted independently but rather as an important part of the general province-wide health education program.

In this field, perhaps even more than in other disease control programs, there is always the danger of holding out false hopes to the public,—hopes for services and results which the physician is not prepared to render. It is essential therefore that all such programs be planned and conducted in the closest possible cooperation with the medical profession. Not infrequently the success of such a program will depend upon a secondary one conducted by the Medical Association for the profession. After all, the profession is expected to supply the services for which public education will create a demand. The two should go hand in hand—public education and the program to inform the physician as to what the public is being told.

It is recommended:

1. THAT THE CANCER RELIEF AND RESEARCH INSTITUTE ENDEAVOR TO ESTABLISH A GENERAL RADIATION CENTER, MAKING FULL USE

OF THE RESEARCH WORK OF THE INSTITUTE REGARDING COSTS OF VARIOUS TYPES OF EQUIPMENT AND METHODS USED IN RADIATION TREATMENTS.

2. THAT THE INSTITUTE PLAN WITH THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION FOR THE COMPLETE PHYSICAL EXAMINATION OF VARIOUS WOMEN'S GROUPS THROUGHOUT THE PROVINCE.

3. THAT THE INSTITUTE ASSIST THE MANITOBA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION IN THE DEVELOPMENT OF A PROGRAM DESIGNED TO ACQUAINT PHYSICIANS THROUGHOUT THE PROVINCE WITH THE MOST RECENT DEVELOPMENTS IN THE KNOWLEDGE OF CANCER AND WITH THE NATURE OF THE INFORMATION BEING GIVEN TO THE PUBLIC.

4. THAT THE INSTITUTE DEVELOP ITS GENERAL EDUCATIONAL OR INFORMATIONAL PROGRAM NOT AS A SEPARATE ENTITY BUT RATHER IN COOPERATION WITH THE HEALTH EDUCATION COUNCIL AS AN IMPORTANT INTEGRAL PART OF THE PROVINCE-WIDE PUBLIC HEALTH EDUCATION PROGRAM.

(See recommendation concerning Health Education Council in the Section on Health Education.)

Table 5-A

ESTIMATED COST OF EFFECTING THE RECOMMENDATIONS OF THIS REPORT

	Salary Increases	Additional Supplies, Travel, etc.	NEW COSTS			Savings	Total
			Salaries	Institutions	Direct Aid		
Executive Office	$ 4,020.00	.....	.....	.....	.....	.....	$ 4,020.00
Stenographer-Clerks of the Department	5,000.00	.....	.....	.....	.....	.....	5,000.00
Statistics and Records	650.00	$1,000.00	$ 3,200.00	.....	.....	.....	4,850.00
Laboratories	500.00	1,000.00	5,950.00	.....	.....	.....	7,450.00
Health Education	1,310.00	1,500.00	2,400.00	.....	.....	.....	5,210.00
Disease Control	770.00	500.00	3,200.00	.....	.....	$ 4,470.00	4,470.00
Maternal and Child Health	.....	.....	3,650.00	.....	$ 500.00[a]	.....	4,150.00
Public Health Nursing	7,730.00	.....	1,800.00	.....	.....	14,000.00	9,530.00
Environmental Sanitation	3,200.00	1,000.00	6,600.00	.....	.....	.....	10,800.00
Psychiatry and Hospitalization	800.00	500.00	6,200.00	$75,000.00[b]	20,000.00	150,000.00	102,500.00
Local Health Service	.....	1,000.00	6,300.00	.....	153,108.00	.....	160,408.00
Public Welfare	9,400.00	1,000.00	3,000.00	.....	.....	.....	13,400.00
TOTAL	$33,380.00	$7,500.00	$42,300.00	$75,000.00	$173,608.00	$168,470.00	$331,788.00
						Less	168,470.00
NET COST							$163,318.00

a. For refresher courses

b. Includes maintenance but not capital cost.

Table 5-B

ESTIMATED COST OF EFFECTING THE RECOMMENDATIONS OF THIS REPORT (Cont'd)

	Salary Increases	Additional Supplies, Travel, etc.	NEW COSTS			Savings	Total
			Salaries	Institutions	Direct Aid		
Public Health—							
Central Office	$19,622.00	$6,000.00	$33,100.00	.....	$ 500.00*a*	$ 18,470.00	$ 58,222.00
Aid to Local Health Service	.....	.....	.....	.....	153,108.00	.....	153,108.00
Total Public Health	$19,622.00	$6,000.00	$33,100.00	.....	$153,608.00	$ 18,470.00	$212,330.00
Psychiatry	$ 603.00	.....	.....	$75,000.00*b*	.....	.....	75,603.00
Hospitalization	1,002.00	500.00	6,200.00	.....	20,000.00	150,000.00	27,702.00
Public Welfare	12,153.00	1,000.00	3,000.00	.....	.....	.....	16,153.00
Grand Total	$33,380.00	$7,500.00	$42,300.00	$75,000.00	$173,608.00	$168,470.00	$331,788.00
Per Cent	10.1	2.3	12.7	22.6	52.3		100.0

NOTE: Stenographer Clerk increases distributed 45 per cent to Health, 45 per cent to Welfare, and 10 per cent to Hospitalization. Executive Office distributed 60 per cent to Health, 15 per cent Mental, 10 per cent Hospitalization, and 15 per cent to Welfare.

a. For refresher courses.

b. Includes maintenance but not capital cost.